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HOUSE OF COMMONS SESSION 1995–96

HEALTH COMMITTEE

Second Report

ALLOCATION OF RESOURCES TO HEALTH AUTHORITIES

Volume I

Report, together with Annexes and the Proceedings of the Committee

Ordered by The House of Commons *to be printed 24 June 1996*

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The Health Committee is appointed under Standing Order No. 130 to examine the expenditure, administration and policy of the Department of Health and associated public bodies.

The Committee consists of 11 Members. It has a quorum of three. Unless the House otherwise orders, all members nominated to the Committee continue to be members of it for the remainder of the Parliament.

The Committee has power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any other committee appointed under the same Standing Order (or to the Committee of Public Accounts and to the Deregulation Committee) its evidence and any other documents relating to matters of common interest;

(d) to meet concurrently with any other such committee for the purposes of deliberating, taking evidence, or considering draft reports.

The membership of the Committee since its nomination on 13 July 1992 has been as follows:

Mrs Marion Roe was elected Chairman on 15 July 1992

Mr John Austin-Walker *(added 12.12.94)*
Mr Michael Bates *(added 6.12.93 and discharged 27.6.94)*
Mr Hugh Bayley *(added 26.10.92)*
Mr Roland Boyes *(discharged 26.10.92)*
Mr James Clappison *(discharged 24.1.94)*
Mr David Congdon
Mr Iain Duncan Smith *(added 24.1.94 and discharged 10.7.95)*
Mr Jonathan Evans *(added 27.6.94 and discharged 28.11.94)*
Mr David Hinchliffe *(discharged 26.10.92)*
Tessa Jowell *(added 26.10.92 and discharged 12.12.94)*
Mr Robert Key *(added 28.11.94 and discharged 1.5.95)*
Mrs Jacqui Lait *(discharged 6.12.93)*
Alice Mahon
Lady Olga Maitland *(added 10.6.96)*
Mr John Marshall *(added 10.7.95)*
Sir Roger Sims
Rev Martin Smyth
Mr Richard Spring *(added 1.5.95 and discharged 10.6.96)*
Mr Michael Trend *(discharged 5.7.93)*
Mr John Whittingdale *(added 5.7.93)*
Audrey Wise

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SECOND REPORT

ALLOCATION OF RESOURCES TO HEALTH AUTHORITIES

The Health Committee has agreed to the following Report:

I. INTRODUCTION

1. As part of last year's inquiry into Public Expenditure issues, based on the response by the Department of Health (DoH) to the Committee's detailed annual Questionnaire,[1] the Committee took written and oral evidence on the methods used to allocate resources to health authorities. Since that evidence was taken, in June and July 1995, the DoH has announced further policy developments.[2]

2. The Committee considered the principles which underlie the current formula used to allocate resources to regional and district health authorities (RHAs and DHAs) in England, the implications of the recent modifications to the formula, the manner and pace of the practical implementation of the modified formula, and its sensitivity to local circumstances. This Report summarises the evidence taken and reviews the current situation, focusing in particular on areas of continuing controversy.

3. **The Committee has no doubt that this has been a useful inquiry. The working of the resource allocation formula is not — as it may at first glance appear — a dry and technical matter of interest only to a few specialist civil servants and academics. The way in which the formula operates is of great importance for Parliament and the general public, because it determines how much money each health authority receives and whether it is a 'fair share' of overall health spending. Ostensibly small changes to the formula can have the effect of adding or removing large amounts from each health authority's allocation.**

4. During its inquiry the Committee took oral evidence from Dr Roy Carr-Hill and Mr Peter Smith of the University of York, representing the research team which produced the analysis upon which some of the recent changes to the formula are based, from Dr Ken Judge of the King's Fund Institute and Dr James Raftery of Wessex Institute of Public Health, from witnesses representing the Healthcare Financial Management Association, from two Directors of Public Health (Dr Stephen Singleton of Northumberland Health Authority and Dr E S Williams of Croydon Health Authority), and from the Secretary of State for Health and DoH officials. The Committee also received 32 written memoranda.

5. We wish to express thanks to the specialist advisers who assisted us during the inquiry: Professor Ronald Akehurst, of the Sheffield Centre for Health and Related Research, Mr Raymond Bennett, formerly of the National Audit Office, Mr Seán Boyle, of the King's Fund Institute, Mr Robert Dredge, Director of Finance at the Royal Wolverhampton Hospitals NHS Trust, and Professor Gerald Wistow, Professor of Health and Social Care at the Nuffield Institute for Health in Leeds.

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[1] The Questionnaire and DoH response are published separately, as Health Committee, Session 1995-96, *Public Expenditure on Health and Personal Social Services: Memorandum received from the Department of Health*, HC 21.

[2] HC 477-II, Ev p177.

II. BACKGROUND

6. In the early years of the NHS, resources were distributed between health authorities largely on the basis of historical patterns of spending, i.e. each authority received its previous year's allocation plus an increase to cover the cost of inflation plus an element for growth. It was increasingly recognised that this 'incremental' system led to inequity and inefficiency. Accordingly, Ministers set up a Resource Allocation Working Party (RAWP) to consider ways of making the allocation of resources more responsive to the health needs of the population.[3]

7. The RAWP report appeared in 1976. It established that the objective of resource allocation should be to secure "equal opportunity of access to health care for people in equal need".[4] Successive governments have accepted this principle. RAWP's recommended formula for allocation was also adopted; this was based on 'weighted capitation', in other words on the estimated population of an area weighted according to the need for health care in that area relative to other areas.

8. Relative need was established by disaggregating the population of each area by age and sex, reflecting the different use of NHS resources made by different age/sex groups, and then by applying a measure to reflect social and economic determinants of need. The measure chosen was the Standardised Mortality Ratio (SMR), used as a proxy for morbidity and therefore, arguably, need. The SMR is defined as "the number of *observed* deaths in an area as a percentage of the *expected* deaths in the area, where expected deaths are calculated by applying national age/sex specific death rates to the age/sex structure of the local population".[5]

9. The RAWP report argued that, in order to secure equity in distributing resources, account had also to be taken of differences between areas, and in particular between the Thames Regions and the rest of the UK, in the cost of providing care. It stated that "cost differentials for and within the Thames Regions are almost certainly significantly greater than those which are attributable to the effect of London Weighting on pay which in any event must be taken into account". Following further research into suitable methodology, a 'market forces factor' adjustment to reflect higher staff costs, over and above London Weighting, was introduced in 1980/81.[6]

10. The RAWP formula continued to operate as a basis for distributing Hospital and Community Health Service (HCHS) funds[7] to RHAs, for onward distribution to DHAs, until 1989. The Government has stated that it remains committed to several principles first established by RAWP, including:

- the overall objective of distributional equity (to secure "equal opportunity of access to health care for people in equal need");
- the use of weighted capitation to achieve that end;
- the principle that resources are distributed between health authorities on the basis of the *relative* needs of their populations, i.e. any weighting which increases one authority's notional population is balanced by a reduction elsewhere; and

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[3] See Roy A. Carr-Hill et al., *A Formula for Distributing NHS Revenues Based on Small Area Use of Hospital Beds: Report of a Study Commissioned from the University of York by the National Health Service Executive* (September 1994), Section 2.

[4] RAWP Report, 1976.

[5] Roy A. Carr-Hill et al., *A Formula for Distributing NHS Revenues* (September 1994), para 2.4-6.

[6] Ev p178.

[7] The HCHS sector of the NHS includes all hospital care and a wide range of community services. Not included within this sector are Family Health Services (FHS), which comprise care provided by GPs, together with dental, pharmaceutical and some ophthalmic services; Central Health and Miscellaneous Services (CHMS), providing centrally-administered services such as welfare foods and support to the voluntary sector; and the administrative costs of the DoH.

- the principle that relative need is a function of three factors, the age structure of the population, nationally-available indicators of local health care needs, and the higher cost of delivering care in some parts of the country.[8]

11. In the late 1980s the NHS Management Board was asked to review the operation of the RAWP formula, with a view to improving the accuracy with which the formula measured relative need. A modified formula, largely based on the Board's recommendations, was adopted in 1989. The changes were seen as being 'fine-tuning' of the system. They included modification of the SMR weighting factor, with condition-specific SMRs replaced by the all-conditions SMR. A Board recommendation that a social deprivation factor be added to the needs weighting was not adopted.[9]

12. The formula in use after 1989 used forecast figures for resident population which were then weighted for:

— the average cost of treating patients in different age bands;

— relative health need, measured by standardised mortality ratios (using the square root of the all-conditions SMR for those aged under 75);[10] and

— the higher costs in the south-east of England.[11]

13. In February 1993 Ministers announced their intention to conduct a further review of the operation of the formula. The primary purpose of the review was to "improve the sensitivity of the current formula for allocating HCHS funds to Regional Health Authorities".[12] The contract for assembling and analysing a large database was given to a team from York University in June 1993. In their work they were guided by a Technical Group and a Steering Group supplied by the DoH.

14. The York team reported in September 1994.[13] They analysed the relative needs of geographical areas, investigated the link between social and economic circumstances and the use of NHS in-patient facilities, and developed separate needs indices for acute and psychiatric in-patient services (replacing the use of SMRs as the sole proxy for morbidity and therefore need).

15. In October 1994 the then Secretary of State announced that she had considered the outcome of the review and had agreed that the existing formula should be modified. The modified formula is intended to inform total revenue allocations inclusive of capital charges. In financial year 1995/96 it was used to allocate resources to RHAs, which had responsibility for distributing funds to DHAs. The regional tier of the NHS was abolished in April 1996, and so with effect from financial year 1996/97 the formula is being used to allocate resources directly from the NHS Executive to DHAs.

16. Although the operation of the modified formula, considered in detail, is a matter of great complexity, the basic steps involved in setting a weighted capitation target for each DHA are simple, and have been set out by the DoH itself as follows:—

"Step 1 — What is the resident population of the DHA?

Step 2 — Weight this by the relative cost of the age profile of the DHA.

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[8] Ev pp26, 103.

[9] *Review of the Resource Allocation Working Party (RAWP) Formula: Final Report by the NHS Management Board* (1988).

[10] The effect of choosing the square root of the SMR in preference to the SMR itself was to reduce the resulting redistribution of money from one area to another.

[11] NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), p2.

[12] Roy A. Carr-Hill et al., *A Formula for Distributing NHS Revenues* (September 1994), para 1.1.

[13] Ibid.

Step 3 — Weight this by indicators of how ill the DHA population is relative to others.

Step 4 — Weight this for relative costs."[14]

These steps produce a weighted population, which when divided by the total population of England and then multiplied by the total HCHS resources available gives the cash target. This target is not necessarily what the DHA will actually receive; how quickly the gap between the DHA's current allocation and its target is closed, probably over a period of years, is ultimately a matter for political decision.

17. The modified formula, like its predecessor, uses population projections calculated each year in respect of each health and local authority area by the Office for National Statistics (ONS)[15] acting in liaison with the Department of the Environment (DoE) and the DoH. The projections are based ultimately on census data, most recently on that from the census held in 1991.[16]

18. The three successive weightings of the forecast resident population figures are:

— *the age/cost adjustment*: reflecting variation in level of demand by age group (in eight age bands);

— *the needs adjustment*: measured by two needs indices, acute and psychiatric, reflecting a number of health and social factors; and

— *the Market Forces Factor (MFF)*: reflecting geographical variation in the cost of staff, land and buildings (including capital charges).

More details of the modified formula are printed with the minutes of evidence.[17]

19. The DoH's own tabular comparison between the previous and new formulae, setting out what it regards as the benefits of the new formula, is as follows:

[14] Ev p105.

[15] Prior to 1 April 1996 the population projections were prepared by the Office of Population Censuses and Surveys (OPCS), which on that date was amalgamated with the Central Statistical Office to form the ONS.

[16] Ev p179.

[17] Ev p103; see also NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994).

TABLE 1: Comparison Between Previous and New Weighted Capitation Formula

PREVIOUS FORMULA	NEW FORMULA
Age/cost curve	More sensitive age/cost curve
Need represented by square root SMR < 75	Two needs indices: i. General & Acute ii. Psychiatric reflecting a number of health and socio-economic variables from 1991 census
Thames Adjustment — London Weighting — Thames Market Forces Factor — Thames 3% & 1% supplement	All embracing staff Market Forces Factor (subsumes LW adjustment) based on external comparators recognising 4 pay zones
Capital charges separate target calculation using age & need as above plus an MFF reflecting geographical differences in land values and building costs down to RHA level	Totally integrated target calculation using age & need as above, and a modified MFF reflecting geographical differences in land values and building costs down to DHA level

Source: NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), Annex 1.

20. A number of criticisms have been made of the way in which the DoH has implemented the new formula, and of what are alleged to be continuing defects in the formula itself. It has variously been claimed that the formula gives too much weighting to age, that rural districts tend to lose out, that a decision by the DoH not to apply the York needs indices to the whole of HCHS spending is inequitable, that the Market Forces Factor is insufficiently sensitive to local differences in costs, and that the proposed pace of progress towards achieving the new targets is too slow.

21. These criticisms were thoroughly aired during the Committee's hearings, and the DoH given an opportunity to respond to them. During the final hearing, the Secretary of State for Health told us that he proposed to take "a continuing and personal interest" in the operation of the formula and the results that it produces.[18] In January 1996 the DoH reported to the Committee that in the light of some of the criticisms that had been made, it had commissioned further research into aspects of needs weighting and into the operation of the Market Forces Factor.[19]

22. The paragraphs which follow discuss the criticisms which have been made of the new allocation system, together with the DoH's responses.

[18] Q332.

[19] Ev p177.

III. THE AGE/COST WEIGHTING

Introduction

23. The first of the weightings applied to local population figures, under both the previous formula and the new one, is intended to reflect variations in the level of need for health services arising from the age-structure of local populations. The very young and the elderly in particular receive significantly more NHS care, as the following table demonstrates:

TABLE 2: Age Bands and Expenditure per head

Age Bands	Expenditure per Head Average 1990-93
Births	1,836
Band 1 (0-4)	388
Band 2 (5-15)	174
Band 3 (16-44)	242
Band 4 (45-64)	358
Band 5 (65-74)	684
Band 6 (75-84)	1,276
Band 7 (85 plus)	2,306

Source: Ev p106.

As the proportion of people in different age groups varies from district to district, it is necessary to adjust allocations to reflect the local age-structure.[20]

24. Both the previous formula and the new one adopt the same basic method of age adjustment. The national average annual cost to the HCHS of a person in each of the above age bands is estimated. For each health authority, the population in each band is multiplied by the relevant cost to produce an age-weighted population.[21]

25. What has changed in the new formula is the way average costs within each age band are calculated. The previous formula used data on occupied in-patient bed days to apportion the cost of all patients using a bed between different age groups. The drawbacks of this method were that it ignored day cases, assumed all specialties to have the same costs per day, and did not distinguish between treatment and 'hotel' (i.e. accommodation and catering) costs.

26. The age/cost element in the new formula attempts to address these deficiencies. Consultants retained by the DoH analysed the costs of in-patient episodes by specialty, differentiating between fixed treatment costs and daily 'hotel' costs. On the basis of this research, new age/cost weightings have been developed for both in-patient and day case episodes. For other HCHS activity the previous methodology will continue to be used: with, in particular, out-patient costs in acute and geriatric specialties being apportioned on the basis of General Household Survey data, and the costs of other out-patients and day care being apportioned *pro rata* to those for in-patients.[22]

27. The 'age/cost curves' generated by the new formula are shown together with those generated by the old one in the following figure:

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[20] Annex 1 to this Report shows how the age structure of health authorities' populations varies across the country.

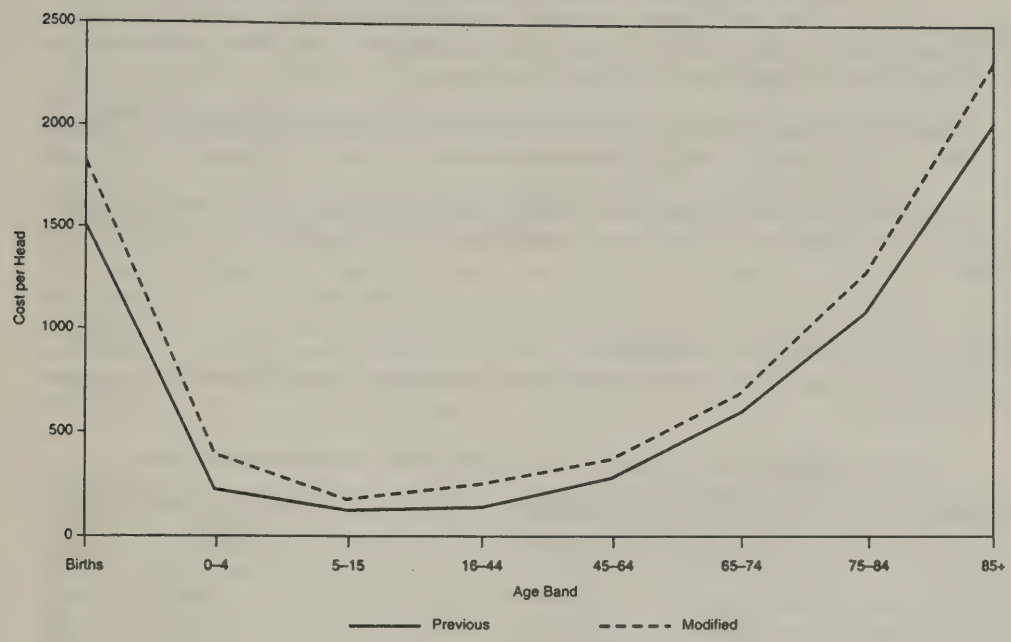
[21] Ev p13.

[22] Ev p107; see also NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), Section 2.

Figure 1

AGE COST CURVE

1994–95 Age/Cost Curve Compared With 1995–96 Age/Cost Curve



Discrepancies between the DoH and York University age/cost curves

28. The Committee received some evidence on discrepancies between the NHS Executive's new age/cost curves and others produced by the York University team as a consequence of their work in developing a new needs weighting (for which, see next section). Mr Peter Smith of York University supplied a table comparing the two sets of curves for different services.[23] This showed that though the variation between the two curves for the total of the services was comparatively small, there were great differences between some of the curves for individual services. The biggest discrepancy was in respect of mental handicap, where the York curve showed much higher costs than the NHS Executive curve in respect of mentally handicapped children, but much lower costs for the elderly.[24] Mr Smith was at pains to point out that he was not claiming that the York curves were superior to the NHS Executive curves. He noted that the Executive had been able to take advantage of a richer dataset than that available to the York team, and its curves might therefore be more reliable. However, the team "share the unease of some commentators with the use of age-cost curves which are different from those used to develop the needs indices".

29. Mr Smith stated that the application of both sets of curves led, as expected, to an overall increase in resources for retirement areas (of up to 23 per cent) because of the age profiles in those areas; the biggest losers were inner city and newer development areas. So

[23] Ev p16.

[24] See Q24.

the age adjustment resulted in large swings in resources between health authorities. However, the apparently large discrepancies between the York and NHS Executive curves "did not themselves in practice give rise to large changes in allocations except among a small number of authorities".[25]

30. Dr Ken Judge of the King's Fund Institute told us that as a member of the steering group appointed by the NHS Executive to make recommendations about the new formula, he had looked into the differences between the York age/cost curves and those produced by the NHS Executive. His judgement was that

> "broadly speaking the age/cost index announced by the Department for the needs formula looks to be the best available at the present time on the evidence available to us".[26]

Dr James Raftery of Wessex Institute of Public Health said that he shared that assessment, though he was "disturbed by the lack of publication of the detailed figures on which it is based".[27]

Effect of the new age/cost weighting

31. The following table illustrates the effects of the change in age/cost weightings, using 1992/93 figures:

TABLE 3: Age/Cost Weights under the Previous and the New Formula

	Previous	New
Births	1,762	1,762
Band 1 0-4	386	374
Band 2 5-15	175	185
Band 3 16-44	224	241
Band 4 45-64	349	355
Band 5 65-74	727	703
Band 6 75-84	1,355	1,280
Band 7 85+	2,442	2,261

Source: NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), Table 1. DoH note: the age/cost weights will be based on the average of 3 years data, e.g. for 1995/96 it will be the average of 1990/91, 1991/92 & 1992/93.

32. It will be seen that the net effect of the changes is slightly to diminish the extent to which the adjustment favours the very young and the elderly. The age/cost element in the new formula will therefore redistribute resources towards areas with a relatively younger age-structure. As the King's Fund Institute pointed out, health authorities in rural and resort/retirement areas will be the principal losers. The Institute said that there was a widespread belief that under the previous formula too much weight was given to elderly people. The changes appeared to be sensible, but "the methods used by the DoH are not widely understood and merit closer and more critical scrutiny".[28]

[25] Ev p14.
[26] Q62.
[27] Ibid.; see also Ev p38.
[28] Ev p27.

33. Some witnesses argued that the degree of weighting towards elderly people under the new formula was still inappropriate. Dr James Raftery of Wessex Institute of Public Health said that he was "unhappy with the very high weighting to the over-85s". He argued that there had been insufficient research into the actual demands placed on the NHS by this group, and the extent to which their use of the private sector, in the form of privately-funded residential care, affected their cost to the NHS.[29]

34. This was an argument developed in more detail by another witness, Dr E S Williams, Director of Public Health at Croydon Health Authority. Dr Williams submitted papers criticising the previous resource allocation formula.[30] He sought to demonstrate "the perverse effect of placing undue weight on the age-structure of a population when allocating resources".[31] One of the papers reported on a study of the relationship between mortality, as a proxy for deprivation, and the proportion of elderly in a district population.[32] The finding was that districts with the highest proportion of elderly people can expect to have the lowest standardised mortality ratios. The most likely explanation for this, Dr Williams contended, was selective migration: those who cannot afford to move to affluent retirement areas are likely to be less healthy than those who can. There were therefore health differentials between elderly populations: old people who live in DHAs with the lowest percentage of elderly people probably have the greatest needs. It followed that an allocation formula that moves money away from younger populations to retirement areas will actually move money away from deprived inner-city areas.

35. Dr Williams claimed that the most significant reason for local differences in age profile was post-retirement migration, with the more affluent and healthy moving to retirement areas; in addition, younger people would migrate to areas of high employment, or for opportunities to study; and, because the ethnic minority population of the UK had a much younger than average age profile, districts with a high proportion of people from ethnic minorities would tend to have young age profiles.[33] He therefore argued that applying the national resource allocation model to district populations was likely to discriminate against inner-city populations, because they had a younger age profile than average, despite having also the highest levels of deprivation and hospitalisation. Sub-regional allocations, he suggested, should be based on the health needs of district populations, disregarding age weighting. At regional level the issue was of less concern, because the variation in age-structure between regions, unlike that between districts, was relatively small.[34]

36. Dr Williams adduced research which he claimed demonstrated that the age-structure of a population was correlated with its health needs, but that the relationship was in the opposite direction to the age/cost curve.[35] The curve was derived from health service costings which assumed that both fixed and flexible costs did not vary between age groups. Dr Williams argued that this "does not reflect the reality of health care costs for the young and elderly".[36] Young patients had shorter lengths of stay but were more likely to require expensive interventions such as intensive care, newer chemotherapeutics and surgery. Elderly patients tended to have longer lengths of stay on account of frailty and social need, but would not use as much high-technology medicine.[37]

37. Finally, Dr Williams argued that the funding formula over-emphasised the importance of hospital service utilisation, and did not take account of the extent to which the health of a population was determined by other factors, such as the level of primary care, health promotion, screening programmes, vaccination and the level of social care. The net effect

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[29] Q62.
[30] Ev pp65-87.
[31] Ev p65.
[32] Ev pp65-67.
[33] Ev p69; Q152.
[34] Ev pp68-69.
[35] Ev pp81-87.
[36] Ev p81.
[37] Ev p81; Q153.

of the formula was complicated by the way that the Market Forces Factor, which was highly correlated with need, partially negated the inappropriate effects of the age/cost curve. The upshot was a redistribution of funds to affluent areas with low standardised mortality, and from the north of England to London and the South-East. Coastal areas in the south of England were particularly favoured.[38]

38. DoH witnesses responded to the criticisms of the age/cost weighting put forward by Dr Williams. They argued that the recent refinements to the weighting meant that it would reflect the extent to which elderly people might spend longer in hospital than younger people but cost less: the new formula separated treatment costs in hospital from hotel costs, and subdivided both according to specialty.[39] DoH officials also argued that the formula as a whole was self-correcting, in that any undue weighting given to a district on grounds of its age-profile would be redressed when the need element "kick[ed] in", as this would take into account the relative healthiness of the population, including the elderly population.[40] With regard to the overall effect of the formula, Mr Colin Reeves, Director of Finance at the NHS Executive, stated that it was

> "very difficult intuitively to say that one component of the formula has a stronger bearing than another component ... it is impossible, because capitation is based on relative measure for each of the components individually, to say whether nationally age is a stronger component than market forces. All we can say at the end of the day is that nationally all three, because they are relative measures, come to zero."[41]

39. The Secretary of State for Health subsequently told the Committee that the degree of weighting towards the elderly produced by the new formula was based on calculations conducted by York University, and

> "unless somebody can demonstrate that the calculations were wrong, it seems to me that the Government should accept the calculations which flow from the policy brief that the consultants were given".[42]

He also asserted that "if it were true that different elderly people's experience of the ageing process differs according to some pattern, then that would be picked up by the needs element in the formula".[43]

40. In a supplementary memorandum submitted after the oral hearings, in September 1995,[44] Dr Williams drew the Committee's attention to a statement in the original York University report that the calculation of costs for each specialty group made by the DoH rested on the assumption that "fixed and variable specialty costs are constant across age groups". The York team stated that this assumption was "unlikely", but "there was no alternative data source which satisfied this study's requirements".[45] Dr Williams agreed with the York team's judgement that the assumption was unlikely; it would imply, for instance, that the average costs of a five-day stay in a surgical specialty for a 50 year old and an 80 year old were the same, an assertion for which he maintained there was no evidence. If the assumption *was* incorrect, Dr Williams asserted, this would mean there was a major flaw in the age/cost curve, liable to produce "a significant distortion of funding allocation to districts".[46] He suggested that the costing element of the age/cost weighting be subjected to further rigorous analysis.

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[38] Ev p82; Q151.
[39] Q240.
[40] Q243.
[41] Q242, 245.
[42] Q306.
[43] Q312.
[44] Ev pp99-100.
[45] Roy A. Carr-Hill et al., *A Formula for Distributing NHS Revenues* (September 1994), para 4.61.
[46] Ev p99.

Age/Cost Weighting: Conclusions

41. The purpose of the age/cost weighting is to allow for varying elements of health *need* associated with different age groups. The terminology currently used to describe the three weightings in the formula — 'age/costs weighting', 'needs weighting' and 'market forces factor' — is therefore somewhat misleading, in that it obscures the fact that the first two weightings both deal with need. The DoH confirmed to us that the so-called 'needs weighting' is intended to "reflect need *over and above* that already accounted for by age" (our italics). We were told that the York team standardised all their measures of utilisation and, where possible, those needs variables that vary substantially with age and sex, and also checked for any residual age effects which might not have been removed by the standardisation process.[47] If the formula is working as it was designed to, variations in the socio-economic status, and therefore in the corresponding actual health needs, of elderly populations ought to be identified and compensated for when the second of the three weightings comes into play.

42. **We consider that the principle of taking account of actual differences in health needs between health authorities arising from variations in the age-structure of the population is sound, but there are concerns about its application. We note the consensus view among our academic witnesses that the current age/cost curves are probably about as accurate as can be. However, we believe that further research into aspects of the age/cost weighting would be useful, to establish whether there are indeed flaws in the practical operation of the weighting, as some of our witnesses, and in particular Dr Williams, alleged. We recommend that the DoH should commission an examination of the reasons for the discrepancies between the York age/cost curves and those of the DoH, and that the detailed calculations upon which the DoH curves were based should be published. We also recommend that there should be a research project to investigate in detail average health care costs for each age band in a carefully-selected sample of health authorities, to establish whether actual utilisation rates are equivalent to those for which weighting is made under the formula. If significant discrepancies were to be revealed by this exercise, then clearly the operation of the age/cost curves would need to be further reviewed.**

IV. THE NEEDS WEIGHTING

The Work of the York Team

43. The Committee's witnesses were generally agreed that the changes to needs assessment proposed by the York University team are welcome ones. Dr Ken Judge of the King's Fund Institute summed up this view when he wrote that the York analysis "is widely acknowledged to be the most impressive and sophisticated undertaken so far in this field". The previous use of standardised mortality ratios for the under-75s as the only need factor employed other than age had been open to the criticism that it under-predicted the needs of deprived areas. Dr Judge argued that the York team's work made possible a more sensitive assessment of morbidity and socio-economic circumstances. In addition, the York team had produced different sets of need indicators for different groups of hospital utilisation, where previously it had only been possible to look at a single group of in-patient episodes.[48]

44. As the York team itself pointed out, the original Resource Allocation Working Party in the mid-1970s

> "would have liked to allocate according to a direct measure of health care needs in the way that we have proposed and we have done in the technical report, but they felt it was impossible to disentangle the effects of supply from utilisation. The difference over the

[47] Ev p179 (Q9).

[48] Ev p27; see also p51, para 3 (HFMA).

last 20 years is much more data has become available and it is therefore possible to use relatively complex statistical techniques to disentangle the effects of supply from the effects of need and that is what we have done."[49]

Application of Needs Indices

45. Although the York team's development of needs indices has been widely welcomed, decisions taken by the DoH as to how to utilise those indices have been the subject of controversy. In adopting the revised formula, the DoH had to decide which needs index to use for distributing funds not relating to in-patient use. The York study was based on in-patient use, but this comprises only about 45 per cent of HCHS spending. The DoH chose to disaggregate total HCHS activity into three categories: an *acute* sector (acute in-patients and out-patients, geriatrics, ambulance services and maternity), a *psychiatric* sector (psychiatric in-patients and out-patients and community services) and an *other* sector (mental handicap, general community services, other hospital and administrative services, and various smaller items).

46. The DoH decided to allocate 64 per cent of the total HCHS budget according to the York acute index, 12 per cent according to the York psychiatric index, and 24 per cent without a needs weighting. This contrasts with the previous system of allocation, under which the 'square root of under-75 SMRs' was applied to the entire HCHS budget. We deal in a later section with the debate about the 'zero-weighted 24 per cent'. The 64:12:24 split reflects existing HCHS spending on the relevant sectors, and the DoH has told us the proportions of the split will be changed annually as necessary to reflect changes in the pattern of spending.[50]

The Choice of Variables

47. The York team adopted the following variables within their two needs indices:

General and acute index

a. Standardised limiting long-standing illness ratio for persons under 75
b. Standardised mortality ratio for persons under 75
c. Proportion of economically active who are unemployed
d. Proportion of pensionable age who are living alone
e. Proportion of dependants in single-carer households

Psychiatric index

a. Standardised mortality ratio for persons under 75
b. Proportion of pensionable age who are living alone
c. Proportion of persons in lone-parent households
d. Proportion of dependants in no-carer households
e. Proportion of adult population permanently sick
f. Proportion born in New Commonwealth.[51]

48. In oral evidence members of the York team were questioned as to why they had chosen these particular variables. Their response was that they had considered many others, such as tenure of home ownership and private rented accommodation, the standards of amenities in households, car ownership, ethnic origin, the extent to which the population included students, the extent of migration within an area and a variety of social-class variables. They found that many of these variables were highly correlated: unemployed people were more likely to be living in overcrowded housing, and so forth.[52] The variables finally chosen were those found to be the best predictors of need:

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[49] Q4.

[50] Ev p179. Since we took our original evidence in this inquiry, the proportions of the split have been changed to 63.4: 11.3: 25.3.

[51] Ev p109.

[52] Q9-10; see also Ev p3.

"We were conscious in doing so of the need to keep the formula as simple as possible so that we tried to remove variables that did not account for much variation."[53]

49. The York team was questioned as to whether ethnicity or population sparsity had been taken into account in drawing up the needs indices. The reply was that existing census data made it difficult for them to be taken into account: there was no question in the census which would enable sparsity to be measured, whilst the question relating to ethnicity, "To which ethnic group do you feel you belong?", measured people's subjective sense of belonging rather than actual ethnic origin.[54] The proportion of local populations born in the New Commonwealth, which could be established, was one of the variables in the psychiatric index.[55] Dr Ken Judge of the King's Fund Institute acknowledged the problems arising from lack of data, but said that he was concerned about the "inadequate attention" given to the question of ethnicity in the York study.[56] (The issues of ethnicity and of population sparsity in rural areas are dealt with further in paragraphs 87, 88 and 99 below.)

50. The York team themselves accepted that further work ought to be done on whether one particular factor related to homelessness but difficult to quantify, the extent of rough sleeping in an area, was properly captured in the existing formula.[57] Mr Keith Ford, Vice-Chairman of the HFMA, also suggested that research should be undertaken into whether the prevalence of low-birth-weight babies should be one of the variables, given that there was a possible correlation with learning disability, which accounted for 4.5 per cent of the zero-weighted element. He wrote that two factors often present in people who later turn out to have a learning disability are low birth-weight and an older than average mother.[58]

The Redistributive Effects of the New Formula

51. The York team published a further paper in May 1995 commenting on the resource allocation consequences of the new needs formula.[59] This argued that the acute index is slightly more redistributive than the previous formula, and that the psychiatric index is very much more redistributive, in particular redirecting resources into the inner cities. The paper further argued that if the zero-weighted 24 per cent of the total budget were to be reallocated according to the York acute index, amounts of up to 5 per cent would be redirected away from the home counties towards the inner cities. The York team wrote that they did not necessarily regard use of the acute model as the best solution, but they used it to illustrate the importance of the issues and "the urgent need for research on the relative need for health care in non-inpatient services".[60]

52. Dr Ken Judge of the King's Fund submitted in evidence an analysis of the redistributive effects of the application of different needs indices upon the funding of DHAs, grouped for purposes of analysis in clusters of areas such as inner-city deprived, urban, affluent rural, and retirement.[61] Dr Judge argued that the results of this exercise show that the previous formula had the effect of benefiting inner London by about 17 per cent, by comparison with allocation on the basis of unweighted population, and had disadvantaged affluent rural areas by about the same amount. The new formula, in the form adopted by the DoH, would benefit inner London by a further 9 per cent, whilst affluent rural areas would benefit by 4 per cent relative to their previous position (though still remaining the largest 'losers'). Finally, if the zero-weighted 24 per cent of funding were to be weighted by what Dr Judge considers is a reasonable amount (a combination of the York acute index and a modified version of the York

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[53] Q12.

[54] Q38-41, 43.

[55] Q40.

[56] Q68.

[57] Q11.

[58] Q96, Ev pp64-5.

[59] Peter Smith and Stuart Peacock, University of York, *The Resource Allocation Consequences of the New NHS Needs Formula* [see Ev pp1-13]; see also Q20.

[60] Ev pp1, 3.

[61] Ev pp26-34.

psychiatric index), inner London would benefit by something like a further 5 per cent and inner-city deprived areas countrywide by a further 3 per cent, while affluent rural areas would lose out by 4 per cent, and dormitory towns by nearly 5 per cent.[62]

53. On the basis of his analysis, Dr Judge argued that overall the new formula is more redistributive, with the age index making relatively little difference but the needs index a significant difference.[63] However, the decision to zero-weight 24 per cent of the total allocation "has the effect of diluting the redistributive impact of the York proposals".[64]

54. Dr James Raftery of Wessex Institute of Public Health also estimated the effect of the old and new formulae.[65] He claimed that a hypothetical comparison between them shows a dramatic shift in the composition of the top gainers. With the new formula, ten of the 15 DHAs gaining more than 10 per cent by comparison with an allocation on the basis of unweighted population are urban DHAs, eight of which are in London. The biggest contributing factor to the London DHAs is the new Market Forces Factor, followed by the needs adjustment; all the urban DHAs lose from the age adjustment. Overall, Dr Raftery concluded that the new formula marks "a big improvement, notably in its modelling of need", but the actual redistributive effects of the new needs indices were not dramatic.[66]

55. Dr Raftery also argued that the redistributive effect of the formula was influenced by the exclusion of consideration of the extent of private health care from the formula. He claimed that as some 13 per cent of the population now had private health care insurance, and up to 30 per cent of some elective procedures were carried out privately, this exclusion needed to be reviewed.[67] Invited to comment on this argument, the DoH stated that "we do not agree that the formula should adjust for the prevalence of private health care insurance" because "the NHS is available to all, regardless of ability to pay, and residents with private health insurance always have the option to use the NHS".[68]

The Debate about the Zero-Weighted 24 Per Cent

56. In its original memorandum to the Committee, the DoH justified its decision to zero-weight 24 per cent of HCHS spending in relation to a breakdown of this spend as follows:—

Mental handicap/learning disability: 4.5 per cent — the York team stated that they were unable to develop a model for mental handicap, and "suggest that further work is undertaken in this area using alternative methodologies".

Community services: 11.5 per cent — the York team said that they had not been able to look explicitly at the determinants of use of community services; they recommended that "the relevance of the data as a basis for allocations in ... community and mental health sectors should be explored further". (Two particular community services have been weighted for need: these are community maternity services, which have been given the acute weight, and community psychiatric services, which have been given the psychiatric weight.)

Administration and Other Hospital Services: 8 per cent — the DoH argued that no needs weighting is applicable here.[69]

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[62] Ev pp28-29, 34 (Table 4).

[63] Q54.

[64] Ev p29.

[65] Ev pp35-41.

[66] Ev p35; Q54.

[67] Ev p41.

[68] Ev p184 (Q5).

[69] Ev p108; see also NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), paras 34-39.

57. In subsequent oral evidence, members of the York team were critical of what one of them, Mr Peter Smith, called the DoH's "controversial" decision to zero-weight, on which the team had not been consulted.[70] Mr Smith said that while the decision was, in the absence of more detailed information, "a matter of judgement", nonetheless "our view would be quite strongly that the same needs weighting should be applied to those 24 per cent of services that are currently given no needs weighting".[71] The team thought it likely that services such as community care, other hospital expenditure and administration, were likely to be proportional to in-patient activity, and therefore the same weighting should be applied. With regard to mental handicap, the other element in the '24 per cent', Mr Smith said that while there was no epidemiological evidence to suggest that the incidence of mental handicap was associated with social deprivation,[72] the judgement of the team was that the implications for the NHS of mental handicap are much more serious in areas with social deprivation than in wealthier areas, and therefore a 'York weighting' ought to be applied in this respect also.

58. Mr Smith took the view that the appropriate weighting for the '24 per cent' would either be one based on the York acute index or, as "a poor second best", the previous weighting used for all spending, i.e. that based on standardised mortality ratios.[73] He described as "very reasonable" the view that a decision to zero-weight was not, as the DoH implied, a refusal to apply a weighting, but a positive decision to apply a particular weighting, which happened to be zero.[74] Dr Judge of the King's Fund Institute associated himself with Mr Smith's comments on this issue. Dr Raftery said he found the zero-weighting decision "hard to justify", though he was not happy with the idea that the standardised mortality ratio might be used as a substitute.[75]

59. The Healthcare Financial Management Association argued that if in principle some weighting was justified for the '24 per cent', and if the DoH's present 'default option' of zero-weighting was maintained until at a later stage a relevant weighting was agreed upon, the formula could lead health authorities to plan on unrealistic long-term assumptions. The HFMA called for the matter to be addressed "as a matter of urgency" so that an acceptable weighting could be found. They suggested that three options be considered: (1) the average of the acute and psychiatric weightings; (2) the acute weighting only (the less redistributive of the two); or (3) a weighting based on SMRs only.[76] The Vice-Chairman of HFMA told the Committee that "using zero sends the wrong signals".[77]

60. The National Association of Health Authorities and Trusts (NAHAT) told the Committee that urgent action was needed to develop appropriate weighting for the 24 per cent, but they did not believe that extension of the York acute and psychiatric weightings as an interim measure would be appropriate.[78]

61. DoH officials mounted a vigorous defence of their decision when they came to give oral evidence. Mr Colin Reeves, Director of Finance at the NHS Executive, drew a clear distinction between the elements which make up the unweighted 24 per cent. With regard to the 8 per cent which was spent on administration, he said, "I remain absolutely unconvinced that there is any statistical evidence or even intuitive grounds for attaching a needs weight to these cases".[79]

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[70] Q21, 31.

[71] Q19.

[72] The DoH has now commissioned research to establish whether this is actually the case: see para 65 below.

[73] Q19-23.

[74] Q33.

[75] Q56.

[76] Ev p51.

[77] Q91.

[78] Ev pp170-2.

[79] Q226.

62. With regard to the 11.5 per cent spent on community health and the 4.5 per cent spent on learning disability, Mr Reeves said that the DoH was committed to introducing weighting, and accepted that "there is likely to be a needs gradient for these services".[80] However, at present the necessary data was not available to enable a weighting to be chosen. He described the suggestion from the York team and others that some positive element for weighting be chosen as "purely based on supposition as opposed to evidence".[81] Given that the new allocation targets would only be achieved over a period of years, he argued, it was better to understate than overstate them. That way no authority would feel aggrieved when a weighting chosen rather arbitrarily in the present state of knowledge was reduced in the light of more accurate information in the future. Given the timescales involved, he claimed, no authority was actually likely to lose out as a result of this decision: "for the average DHA in England the effect is likely to be absolutely minimal in terms of resource redistribution".[82]

63. Giving evidence to the Committee two weeks later, the Secretary of State for Health stated his commitment to extending the needs element of the formula to cover "the whole spectrum of NHS care", and affirmed that he took a personal interest in seeing this done.[83] At the moment, however, there was no evidence on which to assess need in relation to the unweighted 24 per cent. He rejected the argument that weighting based on the SMR should have been retained as an interim measure:

> "I do not know what argument I would use to one authority that was relatively a loser if we went back to the SMR compared with an authority that was relatively a gainer, because the only argument [I could adduce] is that we have always done it that way".[84]

When asked whether it would not be equally difficult to explain the decision to zero-weight to an authority which had lost out by comparison with the previous method, the Secretary of State said that

> "It would require me to go to the relative loser and say that while the rest of this new formula is based on experience and analysis, for this 24 per cent we are basing the weighting on assertion and tradition. I simply do not find that an attractive argument."[85]

64. In January 1996 the DoH submitted further evidence on its plans to conduct research into appropriate ways of weighting for need the currently unweighted 24 per cent.[86] The DoH stated that studies would be commissioned from external analysts on the best ways of measuring need for Community Health Services and the feasibility of utilising national and local datasets for this purpose, with a view to identifying an interim set of needs drivers. The long-term goal was a full national small-area analysis, along the lines of the work for in-patient services, but it had become clear that this was not feasible at present. Invitations to tender for this research have now been issued.

65. With regard to the other elements within the 24 per cent, the DoH announced that it had commissioned a literature review from external academics to establish whether there is any epidemiological evidence to suggest a link between people with learning difficulties and any health or socio-economic factors. In relation to the administration element, work was in hand within the DoH to analyse in more detail the type of services currently recorded in this category of expenditure; on the basis of this work a decision would be taken on whether any needs weighting was appropriate.

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[80] Q226-7.
[81] Q227.
[82] Q230.
[83] Q295-6.
[84] Q304.
[85] Q305.
[86] Ev p177.

66. No date was initially given for the completion of any of these studies. However, in March 1996 we were told that the study to help develop an interim needs weighting for community health services, the 'literature review' of services for people with learning difficulties, and the analysis of expenditure on administration and other services would be completed during 1996/97.[87]

67. Since the receipt of the latest DoH memorandum, a further research paper by the University of York team has been published (February 1996). This contends that many of the programmes covered by the zero-weighted 24 per cent relate to overall policy objectives such as the reduction in incidence of key conditions, early diagnosis and referral, and early discharge. The York team argue that the majority of the community-based programmes necessary to achieve these objectives deal with conditions related to environmental degradation, socio-economic deprivation, and long-standing morbidity, and "are in every case found to be closely associated with accepted measures of need".[88]

Needs Weighting: Conclusions

68. According to the DoH, the decision to zero-weight 24 per cent of HCHS spending is only an interim measure. The Government itself does not claim that zero-weighting is scientifically sound, but argues that until further research has been conducted into what would be an appropriate weighting, to zero-weight is the logical 'default option'. This is debatable: we have some sympathy with the argument that a genuine default option would have been to preserve continuity with the previous formula where the need to supersede it had not been demonstrably made out, and to continue for the time being to weight the 24 per cent on the basis of the 'square root of SMR'. Alternatively, a mix of the York acute and psychiatric indices could have been chosen, on the grounds that this would arguably prove closer to whatever objective evidence-based weighting is eventually arrived at than would zero-weighting.

69. To enable the potential effect of these various options to be studied, we commissioned from the DoH a table, printed as Annex 2 to this Report, showing weighted capitation targets per head of crude population for each health authority. In column D are shown the targets as actually calculated by the Government, i.e. on the basis that 24 per cent of expenditure is zero-weighted. In columns E and F is shown how the targets would look under alternative options. The first of these (Option 1) is that where the needs weighting is based on a combination of the York acute and psychiatric weightings (combined in the same proportions as apply to the currently weighted element of expenditure, i.e. 84.83% acute and 15.17% psychiatric). The second option (Option 2) is that where, as under the previous formula, needs weighting is based on 63.36 per cent general and acute, 11.33 per cent psychiatric, and 25.31 per cent on the square root of standardised mortality ratios. Another table, printed as Annex 3, uses the same calculations but shows them (for greater ease of comparison) in relation to population bases taken as 100.

70. We have used these figures to draw up further tables showing which health authorities are the greatest gainers and losers under the two options, and which would move from being below target to above target, or vice versa, as a result.

71. Table 4 below lists the ten authorities which would be the greatest losers and the ten which would be the greatest gainers if the needs index were to be varied under Option 1 (the York weightings applied to all expenditure). Those authorities' percentage change under Option 2 (using the square root of SMRs) is also shown.

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[87] Ev p180 (Q10).

[88] Dr Mary Brennan and Dr Roy Carr-Hill, University of York, *No Need to Weight Community Health Programmes for Resource Allocation?* [see Ev pp1-13]; quotation from p26.

TABLE 4: Changes in Per Capita Targets Resulting from Restoring a Needs Weighting to the Whole of the HCHS Budget

	1996/97 target	% Change under Option 1 (where total budget is weighted by acute and psychiatric indices)	% Change under Option 2 (where previous SMR weight is applied to the zero-weighted portion)	Change under Option 1 (where total budget is weighted by acute and psychiatric indices)	Change under Option 2 (where previous SMR weight is applied to the zero-weighted portion)
10 Greatest Losers	£	%	%	£	£
East Surrey	401	-5.24	-2.49	-21	-10
West Surrey	386	-5.18	-3.11	-20	-12
North & Mid Hampshire	366	-4.64	-1.91	-17	-7
Cambridge & Huntingdon	352	-4.26	-2.84	-15	-10
Oxfordshire	374	-4.01	-2.41	-15	-9
East and North Hertfordshire	389	-3.86	-2.06	-15	-8
Buckinghamshire	370	-3.78	-1.62	-14	-6
Berkshire	371	-3.77	-1.62	-14	-6
West Hertfordshire	398	-3.77	-2.01	-15	-8
West Sussex	448	-3.35	-2.23	-15	-10
10 Greatest Gainers					
Barnsley	453	3.75	1.99	17	9
Newcastle & North Tyneside	462	3.90	2.38	18	11
Gateshead & South Tyneside	466	4.08	2.79	19	13
St Helens and Knowsley	441	4.08	2.49	18	11
Sunderland	453	4.64	2.87	21	13
Lambeth, Southwark & Lewisham	532	4.70	2.26	25	12
Camden and Islington	555	4.86	1.98	27	11
East London and the City	538	5.58	2.42	30	13
Liverpool	478	5.65	3.35	27	16
Manchester	494	6.88	3.64	34	18
England	426				

72. The table makes clear that the biggest impact, under Option 1, would be on Manchester (which would gain £34 per capita or 6.9 per cent) and on East Surrey (which would lose £21 per capita or 5.2 per cent).

73. Table 5 below sets out which health authorities would move from being below target to above target, or vice versa, under the two options. It shows that under Option 1, eight authorities would switch from below to above target, while 15 would switch from above to below target. Under Option 2 the effect would be less dramatic but still significant, with six authorities switching from above to below target, and 11 switching from below to above target. An additional seven authorities are included which, although already below target, would be brought significantly further below under either of the options.

TABLE 5: Impact of Changes to Needs Weights on Below and Above Target Authorities

	Current Distance from Weighted Capitation Target		Distance from target under Option 1 (where total budget is weighted by acute and psychiatric indices)		Distance from target under Option 2 (where previous SMR weight is applied to the zero-weighted portion)			Growth in HA Budget 1996/97
	£'000	%	£'000	%	£'000	%		%
From Below to Above Target								
Cambridge & Huntingdon	-4,107	-2.55	2,760	1.79	471	0.30	**	1.7
East Norfolk	-2,619	-1.04	3,601	1.47	2,347	0.95	**	1.02
North Yorkshire	-2,427	-0.83	4,216	1.47	512	0.18	**	0.84
Somerset	-1,264	-0.65	5,021	2.67	3,095	1.63	**	0.56
Cornwall and the Isles of Scilly	-909	-0.43	1,541	0.74	2,023	0.98	**	0.85
North & Mid Hampshire	-527	-0.26	8,775	4.59	3,302	1.68	**	1.27
Barking and Havering	-157	-0.09	224	0.13	-157	-0.09	*	1.03
Berkshire	-10,607	-3.67	286	0.1	-5,926	-2.08	*	2.32
More Emphatically Below Target								
Wigan & Bolton	-9,321	-3.63	-18,075	-6.81	-14,583	-5.57		1.84
Kensington, Chelsea and Westminster	-653	-0.35	-5,198	-2.68	-2,054	-1.08		0.60
Lambeth, Southwark & Lewisham	-1,386	-0.35	-19,781	-4.83	-10,231	-2.56		0.65
Sunderland	-687	-0.51	-6,950	-4.92	-4,561	-3.28		0.80
Doncaster	-2,848	-2.2	-6,691	-5.02	-4,621	-3.52		1.49
Barnsley	-2,763	-2.69	-6,617	-6.21	-4,808	-4.59		1.63
North West Lancashire	-5,862	-2.67	-10,545	-4.70	-9,138	-4.09		1.55

TABLE 5 *continued*

	Current Distance from Weighted Capitation Target		Distance from target under Option 1 (where total budget is weighted by acute and psychiatric indices)		Distance from target under Option 2 (where previous SMR weight is applied to the zero-weighted portion)			Growth in HA Budget 1996/97
From Above to Below Target								
Coventry	8	0.01	-2,681	-2.02	-1,785	-1.36	**	0.50
East Riding	366	0.15	-205	-0.09	-775	-0.32	**	0.50
Tees	716	0.29	-8,185	-3.24	-5,405	-2.16	**	0.50
Leeds	1,447	0.47	-3,620	-1.15	-1,457	-0.47	**	0.50
Sefton	626	0.48	-1,136	-0.85	-847	-0.64	**	0.50
Bradford	1,307	0.63	-4,029	-1.88	-2,091	-0.99	**	0.50
East Lancashire	1,608	0.7	-6,093	-2.57	-2,999	-1.28	**	0.51
Calderdale & Kirklees	2,770	1.12	-736	-0.29	-736	-0.29	**	0.50
Sandwell	1,735	1.32	-2,372	-1.75	-1,200	-0.89	**	0.50
Liverpool	3,594	1.59	-9,200	-3.85	-3,992	-1.71	**	0.50
Gateshead & South Tyneside	3,084	1.84	-3,761	-2.15	-1,597	-0.93	**	0.50
Salford & Trafford	4,878	2.45	-1,361	-0.66	872	0.43	*	0.50
East London and the City	9,610	2.93	-8,669	-2.51	1,683	0.50	*	0.50
Newcastle & North Tyneside	8,258	3.75	-327	-0.14	3,019	1.34	*	0.50
Enfield & Haringey	2,506	1.11	-1,283	-0.56	2,980	1.32	*	0.50

* indicates that a switch takes place under Option 1.
** indicates that a switch takes place under either Option.

74. One factor in determining growth in health authority budgets in 1996/97 was distance from target. Thus growth has ranged from zero per cent for Camden & Islington and Manchester to over four per cent for South Essex. Table 5 shows a number of authorities which would move from above to below target if either non-zero weighting option was adopted. As these have also been those authorities which received a minimal uplift of 0.5 per cent in their 1996/97 budgets compared to the national average of 1.1 per cent, this suggests there has already been an impact.

75. **We consider, as does the DoH itself, that the current situation in which some 24 per cent of HCHS expenditure is unweighted for need is unsatisfactory. The sooner the gap in research in this area is filled the better. We strongly urge the DoH to ensure that the various studies it has commissioned are completed in time to allow an evidence-based weighting to be applied to this element in expenditure with effect from April 1997. If for any reason it proves impossible to do this, we recommend that from that date onwards the DoH should apply one of the two weighting options we have discussed in this section of our Report in place of the existing zero-weighting.**

76. **Further research would also be helpful into whether the needs indices currently contain the most appropriate mix of variables, with homelessness, low birth weight and ethnic origin being looked at as possible additions. We recommend that the DoH commission such research.**

V. THE MARKET FORCES FACTOR

77. The third weighting that is applied to the capitation figures under the new allocation formula is the Market Forces Factor (MFF), which is intended to compensate for unavoidable geographical variations in the cost of staff, land and buildings.

78. The previous formula employed three adjustments to take account of the fact that the cost of providing health services varies between areas. These were:

- *London Weighting and Allowances Adjustment*: to take account of these additions to the salaries of many staff working in the capital;
- *Market Forces Factor*: the old MFF was an adjustment over and above London Weighting to take account of higher labour costs in the Thames Regions. This MFF was calculated for three zones: Greater London, Rest of Thames, and Rest of England. It applied only to NHS staff without specific NHS qualifications, i.e. administrative and clerical grades, and maintenance workers.
- *Thames Additions Adjustment*: to take account of the special funding supplements of 3 per cent to North Thames and 1 per cent to South Thames.[89]

79. As part of the new formula, these adjustments are replaced by an integrated Market Forces Factor covering staff costs and capital charges.

80. The new MFF is based on four pay zones:

1 — Inner London
2 — Outer London
3 — Rest of South-East England
4 — Rest of England.[90]

[89] NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), para 41.

[90] Ev pp109, 116. The grouping of DHAs within these zones is set out at Ev p117.

81. The MFF applies to all staff other than medical and dental staff. To avoid circularity (i.e. an inflationary circle whereby health authorities are automatically allocated more money in proportion as their providers increase staff pay), NHS occupational groups are matched with Standard Occupational Classifications (SOCs) as shown in the following table supplied by the DoH:

TABLE 6: Standard Occupation Classifications matched with NHS Staff Groups

NHS Staff Group	SOC used
Maintenance	5 - Craft and related occupation
Admin. and clerical (inc. managers)	1a- Corporate managers
	4a- Clerical occupations
	4b- Secretarial occupations
Unqualified nurses & ancillaries	6b- Personal service occupations
Ambulance staff	8b- Drivers and mobile machine operators
Qualified nurses, midwives, PAMs and P&T	3a- Scientific technicians

Source: Ev p116.

82. Earnings data for these comparator groups, from the New Earnings Survey (NES), is employed in determining the MFF weightings for NHS staff. The index for each staff group is weighted by the proportion of national HCHS expenditure spent on each group, with expenditure on contracted-out staff excluded. The weighted earnings indices for each zone, taking England as a whole to be 100, are as follows: Zone 1, 125.0; Zone 2, 115.9; Zone 3: 104.9; and Zone 4: 93.5. Recognition is then given to the proportion of each DHA's spending incurred in each zone, distinguishing between local provision (services provided within the pay zone where the DHA itself is located) and other provision (services purchased from providers outside that zone).[91]

83. The NES is based on a large sample, so its estimates of average earnings are generally reliable, but the sub-samples for some of the comparator groups used to compute the MFF are small, particularly in inner London. Written evidence from the DoH reveals that the Zone 1 pay index for qualified nurses, professions allied to medicine, and P & T staff is based on a sample of only 700 scientific technicians from outside the NHS; the Zone 1 pay index for unqualified nurses and auxiliaries is based on a sample of 786 personal services workers; and the Zone 1 pay index for ambulance staff is based on a sample of 420 drivers and mobile machine operators.[92]

84. The MFF takes no account of variations in the pay of medical and dental staff. The DoH explained this omission by stating that these staff "are not yet subject to the same market pressures as other staff groups", and in oral evidence Mr Colin Reeves, Director of Finance at the NHS Executive, told us that "we do not believe there is a need for an external comparator in that area"[93] No evidence, however, was adduced in support of these assertions.

[91] NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), paras 47 & 50.

[92] Ev p112-22.

[93] Ev p115; Q248.

85. The DoH have set out the intended effects of the staff MFF. They say that it "reflects an environment of growing trust pay freedom and increasing use of contracted-out services; enables providers to move towards paying the market rate for all staff; and compensates all purchasers who use services within the higher pay zones".[94]

86. The MFF is also intended to reflect geographical variations in land values and building costs. For each DHA there is a specific land and building factor. Land values are based on information supplied by the Valuation Office. The building cost factor is based on data provided by the Building Costs Information Service. There is no specific factor for equipment costs, which are felt not to vary. The DHA factors are converted to a purchaser-based index in the same way as described for pay.[95]

87. Several of the Committee's witnesses suggested that the effect of the new Market Forces Factor on the overall operation of the resource allocation formula was likely to be important, but was difficult to assess because its basis was not clear. The DoH did not employ outside consultants to draw up the new MFF. Mr Peter Smith of York University called for the MFF (together with the age/cost curves) to be subject to the same kind of expert scrutiny that the needs element in the formula had been subjected to. He said that it was possible that there were cost variations between areas that were not allowed for in the MFF: for instance, there might well be extra costs associated with rurality, ethnicity, and the difficulty of attracting staff in shortage specialties.[96]

88. Other witnesses suggested that the MFF took insufficient account of the costs of delivering health services in rural areas or areas with high proportions of people from ethnic minorities. The York University team told the Committee that whereas, by and large, they had found that variables relating to rurality or ethnicity had no influence on health care utilisation, there was evidence that those variables *were* associated with higher costs for delivering health services. There was therefore a case for addressing them within the Market Forces Factor.[97] Dr Judge of the King's Fund Institute said that greater efforts should be made to discover the extent to which population sparsity ought to be taken into account within the MFF.[98] Dr Stephen Singleton, Director of Public Health at Northumberland Health Authority, argued that if the giving of more money to London and the South East through the MFF was justifiable, because the cost of providing services was higher there, then the same principle should apply to rural communities. In those communities staff costs were higher because of travel times, and building costs were higher because economies of scale were less likely to be available.[99]

89. The King's Fund Institute submitted an estimate of the net distributional impact of the changes to the MFF.[100] They claimed that under the previous formula, disregarding the effect of the age-related and other needs factors, London health authorities benefited by on average almost 16 per cent, while other areas lost by up to 3.3 per cent. With the new MFF, London still gains but by less than previously; some other areas lose a little more, but more affluent rural areas and dormitory towns gain by as much as 3 per cent.

90. The King's Fund criticised the DoH's decision to abolish the Thames Additions Adjustment, claiming that "no good reason [was] given for this proposal and there are grounds for believing that the reasons which led to its introduction in the first place remain valid today". They argued that if the adjustment were to be retained, the net effect would be that London would gain an extra 18 per cent as against the 14 per cent it would gain otherwise under the new formula.[101]

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[94] Ev p115.

[95] NHS Executive, *HCHS Revenue Resource Allocation: Weighted Capitation Formula* (October 1994), paras 54-60.

[96] Q34, 50.

[97] Q38.

[98] Q74-5.

[99] Ev pp88-9; Q185-9.

[100] Ev pp28, 33 (Table 3).

[101] Ev p28; Q68.

91. The Healthcare Financial Management Association claimed that the pay zones chosen within the new MFF had steep steps between them which were likely to cause anomalies at the boundaries. In particular, it did "not feel right" that there should be something like a 10 to 12 per cent pay differential between Zones 3 and 4. They recommended that more zones should be introduced to allow for greater gradation. Although in the absence of further research HFMA witnesses were not prepared to commit themselves as to how many further zones there should be, they felt that there could well be a more appropriate proxy for NHS wage costs than the New Earnings Survey. The HFMA also argued that the labour costs adjustment could have two negative effects; that of perpetuating existing diffentials, and of encouraging 'poaching' of staff by hospitals in different pay zones.[102]

92. Dr James Raftery of Wessex Institute of Public Health also criticised the "apparently arbitrary" way the new MFF divides DHAs by zones. He argued that the method of classifying hospitals by the pay zones of their host DHA led to anomalies (with, for instance, amongst London hospitals, St George's Hospital in Tooting, Charing Cross and Hammersmith in Zone 2, but King's College, Greenwich, Lewisham and Newham in Zone 1). He claimed that the health authority for which he worked as a consultant, Merton, Sutton and Wandsworth, stood to lose about £5 million per annum as a consequence of Wandsworth's being placed with Merton and Sutton in Zone 2, even though had it remained a separate health authority it would have been placed in Zone 1. Dr Raftery said that he found it "disturbing that the work on which these methods were based has not been published and that little explanation has been offered".[103]

93. In written evidence, NAHAT commented that the results of the new MFF are "widely felt not to be 'fair'", with, for instance, costs for trusts in Oxford apparently being some 11 to 12 per cent higher than those in Gloucester. NAHAT said they would support a move for further research into the workings of the MFF.[104]

94. The DoH supplied the Committee with a table providing an index of staff costs in the relevant comparator groups for each DHA or county in England.[105] It suggests that there are indeed significant anomalies in the placing of health authorities within zones. Examples put to DoH officials in oral evidence included that of Hillingdon Health Authority, which is placed in Zone 2, yet is shown to have higher local staff costs (i.e. the costs of the comparator occupations' local pay) than all but one of the authorities placed in Zone 1. Likewise Surrey, in Zone 3, has higher local staff costs than six of the London authorities in Zone 2. Three authorities in Zone 4, which is deemed to have local wage costs 93.5 per cent of the national average, have local costs higher than the national average. Several authorities get an increase of 5 per cent in their budget by virtue of their being in Zone 3, despite having local wage costs significantly below the national average.[106] These and other anomalies are illustrated in Table 7 below.

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[102] Q104-6, 109; see also Ev pp50, 52 (para 8).

[103] Ev p41; Q61, 69.

[104] Ev pp170-2.

[105] Ev pp113-4; see also *Official Report*, 20.12.94, col. *1153*, reprinted in Ev pp114-21.

[106] Q249.

TABLE 7: Staff Pay Costs (according to Department of Health's Staff Pay Index) compared to Market Forces Factor Weightings

Local Wage Costs in DHAs as % of national average wage costs	Zone 1 Health Authorities	Zone 2 Health Authorities	Zone 3 Health Authorities	Zone 4 Health Authorities
128	Kensington Chelsea & Westminster			
127	City & East London	Hillingdon		
126				
125	**Zone 1 weighting**			
124	SE London			
123				
122		Ealing Hounslow & Hammersmith		
121				
120	Camden & Islington			
119				
118				
117				
116		**Zone 2 weighting**		
115				
114				
113			Surrey	
112				
111				
110		Barnet; Redbridge & Waltham Forest	Berkshire	
109		Barking & Havering; Croydon		
108				
107		Bromley;Bexley & Greenwich		
106				
105			**Zone 3 weighting**	
104				
103				
102				Wiltshire
101				
100		**National Average Pay Costs**		Suffolk; Avon
99				
98			Bedfordshire	Cumbria
97			Isle of Wight	
96				
95				
94				
93				**Zone 4 weighting**
92				
91				
90				Durham
89				
88			East Sussex	
87				
86				Devon

Source: Ev pp111-4. Figures have been rounded to the nearest percentage point.

95. In reply to this criticism of the operation of the MFF, Mr Malcolm Harris, an Assistant Secretary in the DoH Finance and Performance Directorate, said that it was important not to "get too hooked up on the content of the particular zones" because "any boundary you draw is going to have anomalies within it".[107] The principles underlying the weighting system were sound. Some system was needed to compensate health authorities for the fact that, as another official put it, "one pound in London buys less than one pound in Leeds".[108] The MFF boundaries were based on standard economic regions. At present most health authorities and trusts paid national pay rates, and until a system of totally devolved pay arrived it would not be necessary to consider local labour markets in terms of the NHS.[109]

96. In interpreting the system, Mr Harris said, Zone 4 should be regarded as 100 and the other zones

> "are areas where by and large they need to be compensated not because they are paying higher pay rates, other than London weighting and London allowances, but because they meet other costs such as inability to recruit, faster turnover, employment of agency staff and other inefficiencies which add to cost. That has always been the rationale for giving extra money to London and the South East."[110]

97. When the Secretary of State for Health gave evidence to the Committee two weeks later, he accepted that "a formula that divides the country into four zones is quite clearly not as accurate as it could be" and that at present the MFF was "a comparatively blunt instrument".[111] He reaffirmed what officials had told the Committee, that the DoH was working on ways of making the MFF more accurate, and that this work was now "well advanced".[112] Officials had earlier told the Committee that they accepted there was concern as to whether the formula took sufficient account of the extra cost of living in rural areas, and in particular the extra cost of transport, and that the DoH Resource Allocation Group would undertake further research into this.[113]

98. Officials had also been questioned about whether the choice of comparator occupations for NHS staff grades was appropriate. It was pointed out that large numbers of staff — qualified nurses, midwives and others — were compared to scientific technicians, whose skills were quite different and who numerically were a much smaller group. In reply Mr Harris of the DoH said that in making comparisons on a zonal level he understood that the standard error on the size of sample involved was sufficiently low as to be acceptable. However, the DoH was "not entirely happy" with the existing system of comparison and would be examining alternatives.[114]

99. Following the vigorous criticisms expressed during the Committee's hearings, it is clear that a reappraisal of the MFF as a whole has taken place within the DoH. In January 1996 the DoH told the Committee that "the staff element of the market forces factor, the single most significant element, has attracted adverse comment — the results do not feel fair on the ground".[115] In consequence, a "fundamental review" is to be undertaken, "to re-examine the basis and methodology of the adjustment to ensure that it helps to produce an equitable distribution of resources across the country". The review will also look at the effects of factors such as ethnicity and rurality on the cost of providing services. The work, which will consist of an analysis of local labour markets and provider costs, has been contracted out to the Institute for Employment Research at Warwick University. The DoH hopes that the work

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[107] Q249, 250.
[108] Q248.
[109] Q249, 252.
[110] Q249; see also Q317-8.
[111] Q316.
[112] Q316-17; see also Q252.
[113] Q246-7; see also Q314.
[114] Q255; see also Ev p113.
[115] Ev p177.

may be completed in time for a revised MFF to be utilised in the 1997/98 allocations.[116] In addition, the DoH is conducting an internal review (supervised by a group "which will contain external input") of the other element within the MFF, that which is meant to reflect geographical variations in the cost of land and buildings.

Market Forces Factor: Conclusions

100. **It became clear as our gathering of evidence proceeded that the Market Forces Factor in its present form is deeply flawed. The clumsiness of the current division of the country into only four zones, the anomalies that ensue in the case of particular authorities, the doubts that arise over the choice of comparator occupations (there is no particular reason that we can see, for instance, why the pay of qualified nurses should be linked with that of scientific technicians) and the small samples employed for some of the comparator occupations in inner London suggest that this is an element within the overall formula which is in urgent need of a rethink. We therefore welcome the DoH's announcement of a 'fundamental review', which we believe was largely prompted by the way the shortcomings of the MFF were exposed in the Committee's hearings.**

101. **We recommend that DoH should announce its timetable for completion of the review and should undertake to publish the results in full. We wish to receive assurances that the review will indeed be a 'fundamental' one, examining the whole basis of the existing MFF, that it will include an examination of alternatives to NES data and to the present choice of comparator occupations, and that it will examine the extent to which the MFF's current assumptions about the extent of the cost gap between London/South East and the rest of the country are justified.**

VI. GENERAL ISSUES RAISED BY THE NEW FORMULA

102. Hitherto in this Report we have looked at the working of the component parts of the resource allocation formula, its three individual weightings, and at the recent attempts that have been made to refine these. What ultimately matters, of course, is how these component parts work in combination to generate allocations. It is therefore necessary to consider both the impact on allocations of each of the weightings relative to the other weightings, the overall redistributive impact of the formula, and the pace of change towards meeting the new allocation targets.

The Reliability of Census Data

103. Before doing so it is worth briefly mentioning one possible weak link in the chain of calculation which precedes the application of the three weightings. This is that the population data for each health authority area, the base data to which the weightings are subsequently applied, is ultimately derived from the decennial censuses, and any inaccuracy in the census data will therefore feed through the entire operation of the formula. There are two grounds for suspecting that the population data used in the formula may be less than wholly accurate. One is that by its nature, and despite the best efforts of the Office of National Statistics (formerly the Office of Population Censuses and Surveys) to estimate demographic shifts in the intervening period,[117] population data for each area will become to some degree less reliable year by year during the 10-year gap between censuses. The DoH itself admits that "care is required in interpreting" the ONS interim projections. The other ground for concern is that the original census data may itself be inaccurate because of under-enumeration. This would not matter, as far as the operation of the formula was concerned, if the extent of under-enumeration were to be exactly the same in each health authority area. However, it is possible that under-enumeration is greater in some areas than in others, particularly in the inner cities, as a result both of (in the 1991 census) Community Charge (poll tax) evasion, and of under-enumeration amongst ethnic minorities. The ONS adjusts its figures in an

[116] Ev p180.

[117] Ev p179.

attempt to take account of under-enumeration,[118] but there must remain some doubt as to whether these adjustments do in fact succeed in producing data which accurately reflects population differentials between areas. **We believe that further investigation into this potential deficiency in the data fed into the formula should be carried out by the DoH and ONS, and the results published. We also believe that consideration should be given to the reinstatement of a quinquennial sample census as a possible means of alleviating this problem.**

The Relationship between the Three Weightings

104. The relationship between the three weightings is of great interest. The sequence in which they are applied — first age/cost, then needs, then MFF — is an arbitrary one. We asked the DoH to supply us with figures showing, in respect of each DHA, the allocations that would be generated by each of the six possible sequences of applying the weightings. **The results, which are printed with the Minutes of Evidence, bear out the DoH's comment that the effect on health authority targets of adopting one rather than another of the six possible sequences of weighting is, to all intents and purposes, 'immaterial'.**[119]

105. In principle, each of the three weightings is equally important, although the effect of a particular weighting will vary from area to area, depending on how that weighting varies from the national average. Where the age structure in a health authority varies little from the national average, for example, then the age/cost weighting has little impact on the overall weighting for that authority. If the age structure across the whole country was fairly constant, we would observe little impact on the weighted index as a result of age.

106. For an individual health authority it is possible to calculate what the relative impacts of the three elements are by looking at how they change the weighting of that area relative to the national average. Taking England as 100, and using West Sussex as an example, the effect of age/cost weighting is to add 12 per cent; the effect of needs weighting is to remove 10 per cent; and the MFF adds 3 per cent. The overall impact is then 5 per cent. It would not be correct to claim that more weight, in the sense of *importance*, has been attached to the age/cost element than the others in the case of West Sussex compared to the rest of England. What is true is that the bigger difference between West Sussex and the England average is in age structure and hence this has the bigger impact on the weighting given to the population.[120]

107. It can also be asked which weighting element has the biggest impact on weighted population for all areas of England. Clearly this varies between areas. One area's gain is another's loss, so simply adding gains and losses will not give an answer. It is nonetheless possible to establish the overall changes which are due to the different elements of the formula.

108. The DoH supplied us with data showing the effects of each weighting for health authorities in 1996/97.[121] From this data we calculated, for each health authority, its age/cost, needs and MFF weightings, and a number of statistical measures which illustrate the extent of variation between authorities' relative positions for each weighting element. **From these statistics, set out in Table 8 below, it would appear that the weighting which introduces the greatest variation in each authority's relative position) is the needs weighting, followed by the MFF.**

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[118] Ev p179 (Q3).

[119] Ev p186 (Q7).

[120] Annex 4 to this Report shows the amounts by which each weighting factor changes an authority's weighted target figure per head of crude population.

[121] See Annex 3.

TABLE 8: Measures of Variation (Compared to the National Average) for each Weighting Element

Statistic	Age/Cost Weighting	Needs Weighting	MFF Weighting
Range	92-117	87-125	95-123
Largest increase in target per head of crude population (£) caused by each weighting factor	71 (Isle of Wight)	103 (Manchester)	104 (Kensington, Chelsea & Westminster)
Largest decrease in target per head of crude population (£) caused by each weighting factor	(35) (East London & the City)	(59) (East Surrey)	(21) (Salford & Trafford)
Standard Deviation(1)	4.9	8.5	6.2
No. of authorities whose weighting value falls outside +1 standard deviation of the national average	14(2)	16(3)	16(4)
No. of authorities whose weighting value falls outside -1 standard deviation of the national average	14(5)	17(6)	0
No. of authorities whose weighting value falls outside +2 standard deviations of the national average	6(7)	3(8)	5(9)
No. of authorities whose weighting value falls outside -2 standard deviations of the national average	0	0	0

1: The standard deviation is calculated as follows: $\sqrt{(\sum (w_i-\mu)^2/n)}$, where w_i is each health authority's weighting value and μ is the national average weighting (100).

2: These authorities are: Cornwall & Isles of Scilly; Dorset; East Kent; East Norfolk; East Sussex, Brighton & Hove; Isle of Wight; Lincolnshire; Morecambe Bay; North & East Devon; North West Lancashire; Sefton; Somerset; South & West Devon; West Sussex.

3: These authorities are: Barnsley; Birmingham; Camden & Islington; County Durham; East Lancashire; East London & the City; Gateshead & South Tyneside; Lambeth, Southwark & Lewisham; Liverpool; Manchester; Newcastle & North Tyneside; St. Helen's & Knowsley ; Sunderland; Tees; West Pennine; Wigan & Bolton.

4: These authorities are: Barking & Havering; Barnet; Bexley & Greenwich; Brent & Harrow; Bromley; Camden & Islington; Croydon; Ealing, Hammersmith & Hounslow; East London & the City; Enfield & Haringey; Hillingdon; Kensington, Chelsea & Westminster; Kington & Richmond; Lambeth, Southwark & Lewisham; Merton, Sutton & Wandsworth; Redbridge & Waltham Forest.

5: These authorities are: Bedfordshire; Berkshire; Brent & Harrow; Buckinghamshire; Camden & Islington; Croydon; Ealing, Hammersmith & Hounslow; East London & the City; Lambeth, Southwark & Lewisham; North & Mid Hampshire; North Cheshire; South Staffordshire; St. Helen's & Knowsley; Tees.

6: These authorities are: Berkshire; Bromley; Buckinghamshire; Cambridge & Huntingdon; Dorset; East & North Hertfordshire; East Surrey; Gloucestershire; Herefordshire; Kingston & Richmond; North Essex; Oxfordshire; Somerset; Suffolk; West Kent; West Sussex; Wiltshire.

7: These authorities are: Dorset; East Kent; East Sussex, Brighton & Hove; Isle of Wight; North & East Devon; West Sussex.

8: These authorities are: East London & the City; Liverpool; Manchester.

9: These authorities are: Camden & Islington; Ealing, Hammersmith & Hounslow; East London & the City; Kensington, Chelsea & Westminster; Lambeth, Southwark & Lewisham.

The Pace of Change

109. The net redistributive effects of the formula have been canvassed in evidence by our witnesses, and their views are summarised above at paragraphs 51 to 55. In addition to the evidence there assembled, we asked the DoH to supply its own estimate of these effects. In response, the DoH told us that the actual redistributive effect of the new formula, compared with health authorities' current allocations, has been calculated. We were supplied with figures showing the final 1996/97 distance of authorities from targets.[122] As we have stated above, the target is not necessarily what a DHA will actually receive; how quickly the gap between the DHA's current allocation and its target is closed, probably over a period of years, is ultimately a matter for political decision. The DoH told us that the "redistributive effect is managed by determining the speed at which health authorities are brought closer to their targets", the aim being for "a pace of change which ensures continuity and stability for all health authorities".[123]

110. Several of our witnesses commented on the importance of Ministers' decisions as to the pace of change. The York team observed that "much depends on the speed at which Ministers choose to phase in the new formula", and commented, in respect of last year's allocations, that Ministers "can hardly be said to be implementing the new arrangements zealously".[124] The team added that the 1995/96 Regional allocations were simply a 3.55 per cent cash increase on the previous year's, and made no acknowledgement of the new formula, but that at the sub-regional level the Regions seemed to be adopting the formula, and "there is widespread evidence that Districts are using the implied targets in strategic planning".[125]

111. Dr Ken Judge of the King's Fund Institute concluded that the new approach to weighted capitation had much to commend it, but added that "there are grounds for believing the long-standing commitment 'to ensure an equitable distribution of resources' was being diluted by a Ministerial emphasis on 'safeguarding continuity and stability in the NHS'".[126]

112. The Healthcare Financial Management Association, representing directors of finance, took a different view. They argued for a relatively slow pace of change, on the grounds that "a fast pace of change is not necessarily consistent with achieving equity of access to health care".[127] They said that targets were not entitlements to funds, nor could they be regarded as stable: they might well change as population data changed or as the formula itself was further refined. In addition, the HFMA argued, "a large-scale change over a short timescale tends not to get the most effective use of resources in any organisation", because of difficulties such as those involved in recruiting or laying off staff at relatively short notice or investing in new buildings.[128]

113. Mr Colin Reeves, Director of Finance at the NHS Executive, told us that the Government's approach to the pace of change was not mechanistic but pragmatic. The DoH had "a principle that we are committed to achieving equity as soon as is practicable, which needs to take account of the need to secure both continuity and stability".[129] This approach would take into account three factors: the ability of losing DHAs to be able to cope with reduced resources; the ability of gaining DHAs to use their resources effectively; and the degree to which overall NHS resources would grow each year. The DoH was working on a medium-term strategy whereby health authorities would be given five-year weighted

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[122] We reproduce these figures as Annex 5 to this Report.

[123] Ev p184 (Q5).

[124] Ev p8.

[125] Ibid.

[126] Ev p29.

[127] Ev p53.

[128] Q117.

[129] Q287.

capitation targets and five-year resource redistribution assumptions excluding the effects of any future PES settlements. However, there was no intention of producing "a definitive date for achieving end-state capitation where all DHAs are at parity".[130]

114. The Secretary of State for Health subsequently told us that in his view the process of reaching targets would never be complete, because targets themselves would shift. His aim would be to move authorities closer to target whilst ensuring that unreasonable strains were not imposed on any particular authorities. The pace of change, he said, should be "not so fast as to be unmanageable and not so slow as to be imperceptible".[131]

VII. CONCLUSION

115. **In our Report of last Session on *Priority-Setting in the NHS: Purchasing*, we strongly endorsed certain principles which have been widely and correctly regarded as fundamental to the NHS. The first of these principles was that of equity, which we stated as follows:**

> **"that all patients should receive high-quality health care according to their assessed need; that factors such as age, sex, ethnicity, occupation, social class and geography should have no bearing on the availability or the speed of delivery of services".[132]**

The resource allocation formula we have discussed in this Report is potentially a powerful instrument for securing equity within the NHS. For this reason it is important that every effort is made to ensure that, in the words of the HFMA, it is "as technically correct as humanly possible".[133] We are glad that the present Secretary of State for Health has asserted that he regards the formula as "a key part of the development of the management of the NHS".[134] There is no doubt that there have been cumulative gains over recent years in the sensitivity of the formula, not least due to the work of the York University team. In this Report we have drawn attention to some remaining areas of weakness, including the pace of change, and we hope these will be addressed as a matter of urgency.

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[130] Ibid.

[131] Q320.

[132] Health Committee, First Report of Session 1994-95, HC 134-I.

[133] Q109.

[134] Q298.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. The Committee has no doubt that this has been a useful inquiry. The working of the resource allocation formula is not - as it may at first glance appear - a dry and technical matter of interest only to a few specialist civil servants and academics. The way in which the formula operates is of great importance for Parliament and the general public, because it determines how much money each health authority receives and whether it is a 'fair share' of overall health spending. Ostensibly small changes to the formula can have the effect of adding or removing large amounts from each health authority's allocation. *(Para 3)*

2. We consider that the principle of taking account of actual differences in health needs between health authorities arising from variations in the age-structure of the population is sound, but there are concerns about its application. We note the consensus view among our academic witnesses that the current age/cost curves are probably about as accurate as can be. However, we believe that further research into aspects of the age/cost weighting would be useful, to establish whether there are indeed flaws in the practical operation of the weighting, as some of our witnesses, and in particular Dr Williams, alleged. We recommend that the DoH should commission an examination of the reasons for the discrepancies between the York age/cost curves and those of the DoH, and that the detailed calculations upon which the DoH curves were based should be published. We also recommend that there should be a research project to investigate in detail average health care costs for each age band in a carefully-selected sample of health authorities, to establish whether actual utilisation rates are equivalent to those for which weighting is made under the formula. If significant discrepancies were to be revealed by this exercise, then clearly the operation of the age/cost curves would need to be further reviewed. *(Para 42)*

3. We consider, as does the DoH itself, that the current situation in which some 24 per cent of HCHS expenditure is unweighted for need is unsatisfactory. The sooner the gap in research in this area is filled the better. We strongly urge the DoH to ensure that the various studies it has commissioned are completed in time to allow an evidence-based weighting to be applied to this element in expenditure with effect from April 1997. If for any reason it proves impossible to do this, we recommend that from that date onwards the DoH should apply one of the two weighting options we have discussed in this section of our Report in place of the existing zero-weighting. *(Para 75)*

4. Further research would also be helpful into whether the needs indices currently contain the best mix of variables, with homelessness, low birth weight and ethnic origin being looked at as possible additions. We recommend that the DoH commission such research. *(Para 76)*

5. It became clear as our gathering of evidence proceeded that the Market Forces Factor in its present form is deeply flawed. The clumsiness of the current division of the country into only four zones, the anomalies that ensue in the case of particular authorities, the doubts that arise over the choice of comparator occupations (there is no particular reason that we can see, for instance, why the pay of qualified nurses should be linked with that of scientific technicians) and the small samples employed for some of the comparator occupations in inner London suggest that this is an element within the overall formula which is in urgent need of a rethink. We therefore welcome the DoH's announcement of a 'fundamental review', which we believe was largely prompted by the way the shortcomings of the MFF were exposed in the Committee's hearings. *(Para 100)*

6. We recommend that DoH should announce its timetable for completion of the review and should undertake to publish the results in full. We wish to receive assurances that the review will indeed be a 'fundamental' one, examining the whole basis of the existing MFF, that it will include an examination of alternatives to NES data and to the present choice of comparator occupations, and that it will examine the extent to which the MFF's current assumptions about the extent of the cost gap between London/South East and the rest of the country are justified. *(Para 101)*

7. [There is] one possible weak link in the chain of calculation which precedes the application of the three weightings. This is that the population data for each health authority area, the base data to which the weightings are subsequently applied, is ultimately derived from the decennial censuses, and any inaccuracy in the census data will therefore feed through the entire operation of the formula. There are two grounds for suspecting that the population data used in the formula may be less than wholly accurate. One is that by its nature ... population data for each area will become to some degree less reliable year by year during the 10-year gap between censuses. ... The other ground for concern is that the original census data may itself be inaccurate because of under-enumeration. ... We believe that further investigation into this potential deficiency in the data fed into the formula should be carried out by the DoH and ONS, and the results published. We also believe that consideration should be given to the reinstatement of a quinquennial sample census as a possible means of alleviating this problem. *(Para 103)*

8. From [the] statistics set out in Table 7 ... it would appear that the weighting which introduces the greatest variation in each authority's relative position is the needs weighting, followed by the Market Forces Factor. *(Para 108)*

9. In our Report of last Session on *Priority-Setting in the NHS: Purchasing*, we strongly endorsed certain principles which have been widely and correctly regarded as fundamental to the NHS. The first of these principles was that of equity, which we stated as follows:

> "that all patients should receive high-quality health care according to their assessed need; that factors such as age, sex, ethnicity, occupation, social class and geography should have no bearing on the availability or the speed of delivery of services".

The resource allocation formula we have discussed in this Report is potentially a powerful instrument for securing equity within the NHS. For this reason it is important that every effort is made to ensure that, in the words of the HFMA, it is "as technically correct as humanly possible". We are glad that the present Secretary of State for Health has asserted that he regards the formula as "a key part of the development of the management of the NHS". There is no doubt that there have been cumulative gains over recent years in the sensitivity of the formula, not least due to the work of the York University team. In this Report we have drawn attention to some remaining areas of weakness, including the pace of change, and we hope these will be addressed as a matter of urgency. *(Para 115)*

ANNEX 1

1993 based Resident Population Projections for mid 1996: by Age Band

	AGE BAND														
Health Authority (1 April 1996 Boundaries)	*00-04 Population*	*% of Total*	*05-14 Population*	*% of Total*	*15-44 Population*	*% of Total*	*45-64 Population*	*% of Total*	*65-74 Population*	*% of Total*	*75-84 Population*	*% of Total*	*85 + Population*	*% of Total*	*Total Population*
Avon	62,219	6.34	119,239	12.14	420,064	42.78	220,546	22.46	84,197	8.57	55,376	5.64	20,178	2.05	981,917
Barking and Havering	24,119	6.43	48,602	12.95	156,371	41.67	83,537	22.26	35,638	9.50	20,566	5.48	6,340	1.69	375,271
Barnet	21,046	6.82	38,994	12.63	139,653	45.24	63,877	20.69	22,285	7.22	16,071	5.21	6,662	2.16	308,686
Barnsley	15,110	6.66	29,018	12.79	93,818	41.36	52,734	23.25	20,312	8.95	11,992	5.29	3,751	1.65	226,833
Bedfordshire	40,180	7.30	78,058	14.18	237,511	43.14	124,057	22.53	39,881	7.24	23,019	4.18	7,722	1.40	550,527
Berkshire	54,706	7.02	101,455	13.02	352,185	45.21	173,990	22.33	53,745	6.90	31,825	4.09	11,059	1.42	779,064
Bexley and Greenwich	31,562	7.20	59,746	13.64	191,164	43.63	92,562	21.12	33,513	7.65	21,978	5.02	7,547	1.72	438,170
Birmingham	79,505	7.88	144,868	14.37	437,615	43.40	196,462	19.48	81,114	8.04	51,823	5.14	16,826	1.67	1,008,311
Bradford	37,286	7.67	70,319	14.47	210,021	43.22	98,585	20.29	38,539	7.93	22,623	4.66	8,454	1.74	485,925
Brent and Harrow	32,185	7.04	58,323	12.75	212,412	46.45	96,172	21.03	30,218	6.61	19,865	4.34	8,056	1.76	457,329
Bromley	17,750	6.08	34,213	11.72	119,333	40.87	70,828	24.26	26,422	9.05	16,972	5.81	6,371	2.18	291,987
Buckinghamshire	46,931	6.96	91,759	13.62	292,293	43.37	159,230	23.63	46,737	6.93	27,067	4.02	9,834	1.46	673,950
Bury and Rochdale	28,698	7.30	55,532	14.12	165,284	42.02	88,127	22.40	31,308	7.96	17,979	4.57	6,335	1.61	393,361
Calderdale and Kirklees	40,559	6.94	78,511	13.44	244,474	41.84	132,570	22.69	47,524	8.13	30,022	5.14	10,502	1.80	584,260
Cambridge and Huntingdon	31,970	6.97	56,380	12.29	208,510	45.44	100,630	21.93	32,440	7.07	21,020	4.58	7,810	1.70	458,858
Camden and Islington	25,407	6.91	39,186	10.66	187,776	51.07	69,380	18.87	24,401	6.64	15,497	4.21	5,928	1.61	367,673
Cornwall and Isles of Scilly	27,515	5.63	59,108	12.09	181,179	37.06	123,015	25.16	51,962	10.63	33,729	6.90	12,237	2.50	488,842
County Durham	37,435	6.14	77,881	12.78	248,342	40.75	146,479	24.04	56,994	9.35	31,994	5.25	10,205	1.67	609,428
Coventry	21,137	7.05	41,023	13.68	128,384	42.82	62,199	20.74	25,374	8.46	16,632	5.55	4,997	1.67	299,844
Croydon	23,609	7.23	42,244	12.94	146,960	45.02	70,922	21.72	23,367	7.16	14,065	4.31	5,196	1.59	326,461
Doncaster	19,917	6.74	40,013	13.54	121,514	41.13	67,423	22.82	27,201	9.21	14,825	5.02	4,428	1.50	295,419
Dorset	37,654	5.51	77,355	11.31	257,376	37.65	158,301	23.15	75,212	11.00	55,463	8.11	22,222	3.25	683,680
Dudley	20,230	6.44	39,382	12.54	128,486	40.91	76,801	24.45	27,827	8.86	16,236	5.17	4,993	1.59	314,053
Ealing, Hammersmith and Hounslow	47,634	7.31	77,509	11.89	319,390	49.00	128,714	19.75	41,425	6.36	26,821	4.11	10,232	1.57	651,823
East and North Hertfordshire	34,210	6.97	63,590	12.95	205,950	41.95	115,280	23.48	40,530	8.26	23,520	4.79	7,740	1.58	490,918
East Kent	35,400	6.00	72,260	12.24	223,910	37.93	139,460	23.63	59,970	10.16	42,940	7.27	16,220	2.75	590,257
East Lancashire	33,260	6.48	74,990	14.62	209,640	40.87	115,930	22.60	43,730	8.53	25,840	5.04	9,420	1.84	512,908
East London and the City	55,586	9.14	91,865	15.10	292,902	48.15	100,184	16.47	38,041	6.25	21,870	3.60	7,787	1.28	608,334
East Norfolk	35,690	5.75	73,700	11.87	243,020	39.15	149,810	24.13	62,520	10.07	41,210	6.64	14,690	2.37	620,738
East Riding	35,194	6.10	75,980	13.17	236,811	41.06	133,011	23.06	53,015	9.19	31,938	5.54	10,714	1.86	576,761
East Surrey	22,380	5.45	50,900	12.40	160,540	39.11	105,280	25.65	37,090	9.03	24,230	5.90	10,000	2.44	410,518
East Sussex, Brighton and Hove	41,534	5.71	82,911	11.39	277,807	38.17	164,500	22.60	75,206	10.33	59,561	8.18	26,174	3.60	727,789

Annex 1: 1993 based Resident Population Projections for mid 1996: by Age Band—*continued*

	AGE BAND														
	00-04		*05-14*		*15-44*		*45-64*		*65-74*		*75-84*		*85 +*		
Health Authority (1 April 1996 Boundaries)	*Population*	*% of Total*	*Population*	*% of Total*	*Population*	*% of Total*	*Population*	*% of Total*	*Population*	*% of Total*	*Population*	*% of Total*	*Population*	*% of Total*	*Total Population*
Enfield and Haringey	35,606	7.53	59,830	12.65	220,161	46.54	96,818	20.47	31,684	6.70	20,589	4.35	8,278	1.75	473,064
Gateshead and South Tyneside	22,492	6.24	45,654	12.67	147,808	41.01	82,826	22.98	35,785	9.93	19,890	5.52	5,878	1.63	360,431
Gloucestershire	34,321	6.19	69,611	12.56	220,444	39.79	132,453	23.91	52,008	9.39	33,262	6.00	11,849	2.14	554,046
Herefordshire	10,190	6.13	20,970	12.62	63,680	38.32	40,500	24.37	16,910	10.17	10,510	6.32	3,340	2.01	166,198
Hillingdon	17,294	7.13	31,045	12.79	108,704	44.79	51,599	21.26	18,068	7.45	11,745	4.84	4,126	1.70	242,679
Isle of Wight	6,449	5.16	14,126	11.29	43,961	35.15	31,031	24.81	14,548	11.63	10,652	8.52	4,204	3.36	125,068
Kensington, Chelsea and Westminster	20,400	5.88	27,872	8.04	179,929	51.87	73,851	21.29	23,120	6.67	15,243	4.39	6,349	1.83	346,862
Kingston and Richmond	19,545	6.32	34,743	11.23	139,537	45.09	69,663	22.51	22,490	7.27	16,714	5.40	6,696	2.16	309,486
Lambeth, Southwark and Lewisham	60,060	8.18	93,582	12.74	363,767	49.24	126,661	17.24	49,016	6.67	30,683	4.18	10,756	1.46	734,624
Leeds	47,768	6.58	92,425	12.74	318,637	43.91	155,639	21.45	59,901	8.25	37,588	5.18	13,611	1.88	725,667
Leicestershire	62,348	6.73	122,740	13.24	400,571	43.22	205,337	22.15	74,729	8.06	44,904	4.84	16,118	1.74	926,845
Lincolnshire	35,903	5.82	74,428	12.07	238,027	38.61	152,146	24.68	64,447	10.45	38,897	6.31	12,513	2.03	616,459
Liverpool	33,349	7.05	64,751	13.68	208,375	44.03	95,267	20.13	39,694	8.39	23,756	5.02	7,950	1.68	473,240
Manchester	33,659	7.84	63,127	14.71	197,785	46.08	74,714	17.41	32,371	7.54	20,527	4.78	6,932	1.62	429,213
Merton, Sutton and Wandsworth	45,964	7.39	68,329	10.98	303,997	48.87	120,122	19.31	42,425	6.82	29,028	4.67	12,058	1.94	622,021
Morecambe Bay	19,830	6.38	37,540	12.08	121,780	39.19	73,800	23.75	30,300	9.75	20,130	6.48	7,240	2.33	310,718
Newcastle and North Tyneside	30,081	6.31	58,722	12.32	207,707	43.57	101,240	21.24	43,374	9.10	26,683	5.60	8,838	1.85	476,743
North and East Devon	25,706	5.43	55,645	11.75	178,791	37.76	114,157	24.11	50,352	10.63	34,999	7.39	13,719	2.90	473,466
North and Mid Hampshire	35,077	6.42	72,234	13.23	233,968	42.84	131,445	24.07	39,625	7.26	24,844	4.55	8,795	1.61	546,086
North Cheshire	21,430	6.91	42,450	13.69	131,250	42.33	72,460	23.37	24,370	7.86	13,750	4.43	4,230	1.36	310,039
North Cumbria	18,320	5.75	40,200	12.61	125,880	39.48	78,940	24.76	31,110	9.76	18,420	5.78	5,890	1.85	318,858
North Derbyshire	25,440	6.74	45,680	12.11	149,560	39.64	92,800	24.60	35,560	9.43	21,450	5.69	6,660	1.77	377,248
North Essex	53,850	6.15	108,710	12.42	355,880	40.64	211,330	24.14	77,970	8.90	50,050	5.72	17,700	2.02	875,588
North Nottinghamshire	22,090	5.64	50,380	12.86	161,130	41.14	95,040	24.27	35,590	9.09	20,790	5.31	6,550	1.67	391,668
North Staffordshire	32,280	6.78	60,430	12.69	197,720	41.51	110,250	23.15	43,480	9.13	24,550	5.15	7,490	1.57	476,298
North West Anglia	25,190	6.12	52,240	12.70	167,080	40.61	95,420	23.19	39,960	9.71	23,870	5.80	7,610	1.85	411,468
North West Lancashire	30,390	6.49	56,580	12.09	180,470	38.55	110,060	23.51	48,210	10.30	30,930	6.61	11,360	2.43	468,098
North Yorkshire	42,779	5.80	87,999	11.94	293,464	39.81	181,189	24.58	70,253	9.53	44,465	6.03	16,878	2.29	737,125
Northamptonshire	42,026	6.92	84,337	13.88	257,123	42.31	138,477	22.79	46,711	7.69	28,978	4.77	9,996	1.64	607,746
Northumberland	17,528	5.64	38,271	12.32	122,786	39.52	78,656	25.31	30,370	9.77	17,468	5.62	5,545	1.78	310,722
Nottingham	45,720	7.07	81,100	12.54	280,540	43.37	140,890	21.78	54,480	8.42	32,710	5.06	11,340	1.75	646,878
Oxfordshire	41,759	6.93	78,143	12.97	269,380	44.70	131,369	21.80	44,115	7.32	27,530	4.57	10,289	1.71	602,683
Portsmouth and SE Hampshire	33,830	6.34	68,300	12.81	222,130	41.66	120,610	22.62	47,270	8.86	30,250	5.67	10,770	2.02	533,258
Redbridge and Waltham Forest	34,362	7.51	59,247	12.95	206,878	45.21	93,444	20.42	32,231	7.04	22,289	4.87	9,066	1.98	457,615
Rotherham	17,480	6.81	33,832	13.18	106,749	41.59	60,029	23.39	21,916	8.54	12,760	4.97	3,793	1.48	256,657

Annex 1: 1993 based Resident Population Projections for mid 1996: by Age Band—*continued*

Health Authority (1 April 1996 Boundaries)	*00-04 Population*	*% of Total*	*05-14 Population*	*% of Total*	*15-44 Population*	*% of Total*	*45-64 Population*	*% of Total*	*65-74 Population*	*% of Total*	*75-84 Population*	*% of Total*	*85+ Population*	*% of Total*	*Total Population*
	AGE BAND														
Salford and Trafford	30,031	6.75	59,076	13.28	184,038	41.36	99,769	22.42	38,868	8.74	24,487	5.50	8,568	1.93	444,935
Sandwell	21,234	7.24	39,588	13.50	120,624	41.14	63,407	21.63	26,782	9.13	16,534	5.64	4,918	1.68	293,185
Sefton	17,277	5.89	37,950	12.93	113,512	38.68	70,212	23.92	29,307	9.99	18,253	6.22	6,880	2.34	293,489
Sheffield	33,248	6.30	62,395	11.83	228,858	43.40	114,489	21.71	45,420	8.61	32,005	6.07	10,835	2.05	527,348
Shropshire	26,912	6.35	55,354	13.06	169,565	40.02	103,872	24.52	37,690	8.90	22,578	5.33	7,615	1.80	423,684
Solihull	12,059	5.99	26,011	12.92	78,780	39.12	52,771	26.20	18,299	9.09	10,126	5.03	3,241	1.61	201,385
Somerset	28,814	5.95	59,985	12.38	185,306	38.24	116,470	24.03	49,568	10.23	32,331	6.67	12,026	2.48	484,597
South and West Devon	35,344	5.97	71,585	12.09	233,569	39.43	137,183	23.16	57,868	9.77	40,681	6.87	15,991	2.70	592,318
South Cheshire	42,010	6.25	86,420	12.85	271,790	40.42	166,190	24.72	59,060	8.78	35,080	5.22	11,690	1.74	672,338
South Derbyshire	34,560	6.23	70,830	12.78	234,390	42.28	127,110	22.93	48,170	8.69	29,480	5.32	9,750	1.76	554,388
South Essex	48,320	6.89	88,400	12.61	292,530	41.72	162,000	23.10	60,270	8.59	37,300	5.32	12,340	1.76	701,258
South Humber	22,416	7.08	43,190	13.64	124,879	39.44	74,769	23.62	28,715	9.07	17,032	5.38	5,506	1.74	316,605
South Lancashire	21,430	6.87	41,940	13.44	124,860	40.03	77,630	24.89	25,740	8.25	15,030	4.82	5,210	1.67	311,938
South Staffordshire	34,920	5.95	77,850	13.26	243,400	41.46	148,140	25.23	47,590	8.11	26,570	4.53	8,500	1.45	587,069
Southampton and SW Hampshire	33,413	6.27	65,756	12.34	221,342	41.53	121,115	22.72	48,065	9.02	31,866	5.98	11,375	2.13	533,030
St Helen's and Knowsley	23,135	6.92	46,915	14.04	139,925	41.88	75,705	22.66	29,004	8.68	15,008	4.49	4,327	1.30	334,118
Stockport	18,276	6.26	37,618	12.89	119,317	40.88	70,167	24.04	25,772	8.83	15,207	5.21	5,426	1.86	291,881
Suffolk	42,098	6.35	86,423	13.03	262,844	39.62	154,198	23.24	62,032	9.35	41,165	6.20	14,621	2.20	663,479
Sunderland	19,983	6.70	40,637	13.63	126,801	42.54	66,431	22.29	26,358	8.84	13,512	4.53	4,259	1.43	298,080
Tees	37,392	6.70	80,313	14.40	229,637	41.17	127,891	22.93	49,369	8.85	25,515	4.57	7,497	1.34	557,713
Wakefield	21,523	6.73	42,145	13.18	133,993	41.90	74,626	23.34	26,962	8.43	15,778	4.93	4,634	1.45	319,760
Walsall	18,207	6.88	35,832	13.55	107,843	40.78	62,514	23.64	23,263	8.80	12,943	4.89	3,777	1.43	264,478
Warwickshire	30,324	6.08	62,226	12.48	202,150	40.54	125,029	25.07	43,921	8.81	26,432	5.30	8,481	1.70	498,661
West Hertfordshire	34,120	6.58	66,140	12.75	218,370	42.11	121,700	23.47	42,760	8.25	26,200	5.05	9,200	1.77	518,588
West Kent	63,580	6.59	126,240	13.09	401,640	41.65	232,040	24.06	77,280	8.01	47,000	4.87	16,480	1.71	964,358
West Pennine	34,673	7.27	67,496	14.14	200,523	42.02	106,312	22.28	37,281	7.81	23,132	4.85	7,673	1.61	477,188
West Surrey	42,160	6.63	77,700	12.21	263,970	41.49	154,250	24.24	52,290	8.22	33,060	5.20	12,720	2.00	636,248
West Sussex	41,973	5.77	85,229	11.72	276,192	37.97	171,486	23.58	75,095	10.33	54,546	7.50	22,693	3.12	727,311
Wigan and Bolton	40,231	6.88	79,375	13.58	244,319	41.80	137,140	23.46	46,403	7.94	28,179	4.82	8,731	1.49	584,476
Wiltshire	39,371	6.57	77,404	12.92	251,859	42.03	137,638	22.97	50,874	8.49	31,213	5.21	10,796	1.80	599,253
Wirral	21,089	6.32	45,245	13.56	132,470	39.69	77,350	23.18	30,821	9.24	19,611	5.88	7,037	2.11	333,721
Wolverhampton	17,588	7.22	32,555	13.36	102,260	41.96	51,742	21.23	22,606	9.28	12,957	5.32	3,889	1.60	243,695
Worcestershire	33,740	6.23	68,280	12.60	220,930	40.78	133,930	24.72	46,660	8.61	28,720	5.30	9,420	1.74	541,778

ANNEX 2

Calculation of 1996–97 Weighted Capitation Targets: Effect of Weightings

	A	B	C	D	E	F	G
	Unweighted Target per head of crude population	*Age Weighted Target per head of crude population*	*Age and Need Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population (1)*	*Age, Need and MFF Weighted Target per head of crude population (2)*	**Actual HCHS Allocation per head of crude population**
	£	£	£	£	£	£	£
Avon	426	430	409	395	388	390	**399**
Barking and Havering	426	426	422	462	461	462	**461**
Barnet	426	423	398	444	435	436	**466**
Barnsley	426	422	473	453	470	462	**441**
Bedfordshire	426	399	378	390	382	387	**368**
Berkshire	426	397	358	371	357	365	**357**
Bexley and Greenwich	426	416	422	460	462	459	**470**
Birmingham	426	418	461	443	457	451	**461**
Bradford	426	414	447	429	440	436	**432**
Brent and Harrow	426	405	407	454	454	449	**474**
Bromley	426	438	402	441	427	430	**420**
Buckinghamshire	426	398	357	370	356	364	**356**
Bury and Rochdale	426	411	446	429	440	437	**423**
Calderdale and Kirklees	426	420	440	423	429	429	**427**
Cambridge and Huntingdon	426	409	364	352	337	342	**342**
Camden and Islington	426	400	467	555	582	566	**635**
Cornwall and Isles of Scilly	426	461	446	428	423	422	**427**
County Durham	426	422	471	452	468	462	**444**
Coventry	426	423	451	434	443	440	**433**
Croydon	426	405	395	430	427	426	**422**
Doncaster	426	417	456	438	451	444	**429**
Dorset	426	488	451	437	425	426	**442**
Dudley	426	420	414	396	394	397	**390**
Ealing, Hammersmith and Hounslow	426	399	424	479	489	484	**496**
East and North Hertfordshire	426	415	372	389	374	381	**390**
East Kent	426	467	455	470	465	465	**445**
East Lancashire	426	417	465	447	462	456	**450**
East London and the City	426	391	467	538	568	551	**554**
East Norfolk	426	452	422	404	394	396	**400**
East Riding	426	426	429	413	414	415	**413**
East Surrey	426	441	382	401	380	391	**407**
East Sussex, Brighton and Hove	426	493	477	491	486	484	**466**
Enfield and Haringey	426	407	427	477	485	476	**482**
Gateshead and South Tyneside	426	426	484	466	485	479	**474**
Gloucestershire	426	440	406	390	379	384	**408**

Annex 2: Calculation of 1996–97 Weighted Capitation Targets: Effect of Weightings—*continued*

	A	B	C	D	E	F	G
	Unweighted Target per head of crude population	*Age Weighted Target per head of crude population*	*Age and Need Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population (1)*	*Age, Need and MFF Weighted Target per head of crude population (2)*	**Actual HCHS Allocation per head of crude population**
	£	£	£	£	£	£	£
Herefordshire	426	444	408	391	379	384	**399**
Hillingdon	426	413	390	426	418	421	**439**
Isle of Wight	426	497	482	490	485	486	**501**
Kensington, Chelsea and Westminster	426	408	438	542	555	546	**544**
Kingston and Richmond	426	426	392	432	419	424	**455**
Lambeth, Southwark and Lewisham	426	400	465	532	557	544	**531**
Leeds	426	420	442	426	433	430	**428**
Leicestershire	426	415	400	384	379	381	**373**
Lincolnshire	426	445	430	411	406	410	**416**
Liverpool	426	416	497	478	505	494	**486**
Manchester	426	409	512	494	528	512	**533**
Merton, Sutton and Wandsworth	426	415	421	458	460	458	**472**
Morecambe Bay	426	452	449	431	430	433	**450**
Newcastle and North Tyneside	426	427	481	462	480	473	**479**
North and East Devon	426	471	438	422	412	413	**432**
North and Mid Hampshire	426	405	356	366	349	359	**366**
North Cheshire	426	405	429	413	421	420	**445**
North Cumbria	426	431	428	413	412	419	**416**
North Derbyshire	426	435	433	415	414	416	**411**
North Essex	426	432	397	408	395	400	**383**
North Nottinghamshire	426	418	429	410	413	411	**408**
North Staffordshire	426	422	452	433	442	441	**425**
North West Anglia	426	431	418	403	398	399	**397**
North West Lancashire	426	458	487	469	479	476	**457**
North Yorkshire	426	443	414	399	390	395	**396**
Northamptonshire	426	411	389	377	370	377	**380**
Northumberland	426	429	436	420	422	424	**416**
Nottingham	426	421	434	416	421	418	**405**
Oxfordshire	426	408	364	374	359	365	**354**
Portsmouth and South East Hampshire	426	432	415	425	419	421	**416**
Redbridge and Waltham Forest	426	418	429	470	474	469	**464**
Rotherham	426	414	451	431	443	437	**424**
Salford and Trafford	426	428	469	448	462	457	**459**
Sandwell	426	428	469	449	463	459	**455**
Sefton	426	448	467	448	454	453	**450**
Sheffield	426	434	472	453	466	458	**469**

Annex 2: Calculation of 1996–97 Weighted Capitation Targets: Effect of Weightings—*continued*

	A	B	C	D	E	F	G
	Unweighted Target per head of crude population	*Age Weighted Target per head of crude population*	*Age and Need Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population*	*Age, Need and MFF Weighted Target per head of crude population (1)*	*Age, Need and MFF Weighted Target per head of crude population (2)*	**Actual HCHS Allocation per head of crude population**
	£	£	£	£	£	£	£
Shropshire	426	425	409	391	386	388	**384**
Solihull	426	419	390	377	367	371	**384**
Somerset	426	456	418	402	389	393	**399**
South and West Devon	426	460	449	432	428	427	**437**
South Cheshire	426	422	405	390	385	389	**391**
South Derbyshire	426	420	420	401	401	404	**408**
South Essex	426	425	407	423	416	420	**390**
South Humber	426	429	434	415	416	420	**424**
South Lancashire	426	419	415	400	399	401	**407**
South Staffordshire	426	404	385	370	363	370	**376**
Southampton and South West Hampshire	426	437	411	420	411	415	**399**
St. Helen's and Knowsley	426	406	459	441	459	452	**438**
Stockport	426	424	417	403	401	404	**393**
Suffolk	426	442	404	389	377	381	**390**
Sunderland	426	408	473	453	474	466	**451**
Tees	426	406	456	438	454	449	**439**
Wakefield	426	412	445	426	436	433	**439**
Walsall	426	414	441	423	432	431	**414**
Warwickshire	426	422	402	388	381	385	**404**
West Hertfordshire	426	418	378	398	383	390	**403**
West Kent	426	416	387	402	392	399	**386**
West Pennine	426	413	455	437	450	447	**430**
West Surrey	426	427	370	386	366	374	**398**
West Sussex	426	477	434	448	433	438	**427**
Wigan and Bolton	426	411	458	440	455	449	**423**
Wiltshire	426	422	386	373	361	367	**389**
Wirral	426	437	466	447	457	454	**445**
Wolverhampton	426	424	463	444	457	451	**440**
Worcestershire	426	423	390	376	365	369	**378**

Notes:

1. As per the Health Select Committee Hypothetical Model (a) ie Need weighting based on 84.83 per cent for general and acute, 15.17 per cent for psychiatric (25.31 per cent assigned pro rata to acute and psychiatric).

2. As the Health Select Committee Hypothetical Model (b) ie Need weighting based on 63.36 per cent general and acute, 11.33 per cent psychiatric, 25.31 per cent on square root SMR.

Source: PE 1M, Table 3 (updated 31.5.96); PE 1P, (DoH).

ANNEX 3

Calculation of 1996–97 Weighted Capitation Targets: Effects of Weightings

Crude Population = 100

	A	B	C	D	E	F
	Crude Population = 100	*Index for Age Adjustment*	*Index for Age and Need Adjustment*	*Index for Age, Need and MFF Adjustment*	*Index for Age, Need and MFF Adjustment (1)*	*Index for Age, Need and MFF Adjustment (2)*
Avon	100	101	96	93	91	92
Barking and Havering	100	100	99	109	108	109
Barnet	100	99	93	104	102	102
Barnsley	100	99	111	106	110	108
Bedfordshire	100	94	89	92	90	91
Berkshire	100	93	84	87	84	86
Bexley and Greenwich	100	98	99	108	109	108
Birmingham	100	98	108	104	107	106
Bradford	100	97	105	101	103	102
Brent and Harrow	100	95	96	107	107	105
Bromley	100	103	94	104	100	101
Buckinghamshire	100	93	84	87	84	85
Bury and Rochdale	100	97	105	101	103	103
Calderdale and Kirklees	100	99	103	99	101	101
Cambridge and Huntingdon	100	96	85	83	79	80
Camden and Islington	100	94	110	130	137	133
Cornwall and Isles of Scilly	100	108	105	101	99	99
County Durham	100	99	111	106	110	109
Coventry	100	99	106	102	104	103
Croydon	100	95	93	101	100	100
Doncaster	100	98	107	103	106	104
Dorset	100	115	106	103	100	100
Dudley	100	99	97	93	93	93
Ealing, Hammersmith and Hounslow	100	94	100	113	115	114
East and North Hertfordshire	100	97	88	91	88	89
East Kent	100	110	107	110	109	109
East Lancashire	100	98	109	105	109	107
East London and the City	100	92	110	126	133	129
East Norfolk	100	106	99	95	93	93
East Riding	100	100	101	97	97	97
East Surrey	100	104	90	94	89	92
East Sussex, Brighton and Hove	100	116	112	115	114	114
Enfield and Haringey	100	96	100	112	114	112
Gateshead and South Tyneside	100	100	114	109	114	112
Gloucestershire	100	103	95	92	89	90
Herefordshire	100	104	96	92	89	90
Hillingdon	100	97	92	100	98	99
Isle of Wight	100	117	113	115	114	114
Kensington, Chelsea and Westminster	100	96	103	127	130	128
Kingston and Richmond	100	100	92	102	99	100
Lambeth, Southwark and Lewisham	100	94	109	125	131	128
Leeds	100	99	104	100	102	101
Leicestershire	100	97	94	90	89	90
Lincolnshire	100	105	101	96	95	96
Liverpool	100	98	117	112	119	116
Manchester	100	96	120	116	124	120
Merton, Sutton and Wandsworth	100	97	99	108	108	108
Morecambe Bay	100	106	106	101	101	102
Newcastle and North Tyneside	100	100	113	109	113	111
North and East Devon	100	111	103	99	97	97
North and Mid Hampshire	100	95	84	86	82	84
North Cheshire	100	95	101	97	99	99
North Cumbria	100	101	101	97	97	98
North Derbyshire	100	102	102	97	97	98
North Essex	100	102	93	96	93	94
North Nottinghamshire	100	98	101	96	97	97
North Staffordshire	100	99	106	102	104	104
North West Anglia	100	101	98	95	94	94
North West Lancashire	100	108	114	110	113	112
North Yorkshire	100	104	97	94	92	93
Northamptonshire	100	97	91	89	87	89
Northumberland	100	101	102	99	99	100
Nottingham	100	99	102	98	99	98
Oxfordshire	100	96	86	88	84	86
Portsmouth and South East Hampshire	100	101	98	100	98	99
Redbridge and Waltham Forest	100	98	101	110	111	110
Rotherham	100	97	106	101	104	103
Salford and Trafford	100	101	110	105	108	107
Sandwell	100	101	110	106	109	108
Sefton	100	105	110	105	107	106

Annex 3: Calculation of 1996–97 Weighted Capitation Targets: Effects of Weightings—*continued*

	A	B	C	D	E	F
	Crude Population = 100	*Index for Age Adjustment*	*Index for Age and Need Adjustment*	*Index for Age, Need and MFF Adjustment*	*Index for Age, Need and MFF Adjustment (1)*	*Index for Age, Need and MFF Adjustment (2)*
Sheffield	100	102	111	106	109	108
Shropshire	100	100	96	92	91	91
Solihull	100	99	92	89	86	87
Somerset	100	107	98	94	91	92
South and West Devon	100	108	105	101	101	100
South Cheshire	100	99	95	92	90	91
South Derbyshire	100	99	99	94	94	95
South Essex	100	100	96	99	98	99
South Humber	100	101	102	97	98	99
South Lancashire	100	98	97	94	94	94
South Staffordshire	100	95	91	87	85	87
Southampton and South West Hampshire	100	103	97	99	96	97
St. Helen's and Knowsley	100	95	108	104	108	106
Stockport	100	100	98	95	94	95
Suffolk	100	104	95	91	89	90
Sunderland	100	96	111	106	111	110
Tees	100	95	107	103	107	105
Wakefield	100	97	104	100	103	102
Walsall	100	97	104	99	101	101
Warwickshire	100	99	95	91	90	91
West Hertfordshire	100	98	89	93	90	92
West Kent	100	98	91	94	92	94
West Pennine	100	97	107	103	106	105
West Surrey	100	100	87	91	86	88
West Sussex	100	112	102	105	102	103
Wigan and Bolton	100	96	108	103	107	105
Wiltshire	100	99	91	88	85	86
Wirral	100	103	109	105	107	107
Wolverhampton	100	100	109	104	107	106
Worcestershire	100	99	92	88	86	87

Notes

1. As per the Health Select Committee Hypothetical Model (a), ie. Need weighting based on 84.83 per cent for general and acute, 15.17 per cent for psychiatric (25.31 per cent assigned pro rata to acute and psychiatric).

2. As the Health Select Committee Hypothetical Model (b), ie. Need weighting based on 63.36 per cent general and acute, 11.33 per cent psychiatric, 25.31 per cent of square root SMR.

Source: PE 1M, Table 4, (DoH).

ANNEX 4

Calculation of 1996–97 Weighted Capitation Targets: Further Analysis

	A	B	C	D	E
	Unweighted Target per head of crude population	*Age Weighting increases/ (decreases) target by*	*Needs Weighting increases/ (decreases) target by*	*MFF weighting increases/ (decreases) target by*	*Age, Need and MFF Weighted Target per head of crude population*
	£	£	£	£	£
Avon	426	4	(21)	(14)	395
Barking and Havering	426	0	(4)	40	462
Barnet	426	(3)	(25)	46	444
Barnsley	426	(4)	51	(20)	453
Bedfordshire	426	(27)	(21)	12	390
Berkshire	426	(29)	(39)	13	371
Bexley and Greenwich	426	(10)	6	38	460
Birmingham	426	(8)	43	(18)	443
Bradford	426	(12)	33	(18)	429
Brent and Harrow	426	(21)	2	47	454
Bromley	426	12	(36)	39	441
Buckinghamshire	426	(28)	(41)	13	370
Bury and Rochdale	426	(15)	35	(17)	429
Calderdale and Kirklees	426	(6)	20	(17)	423
Cambridge and Huntingdon	426	(17)	(45)	(12)	352
Camden and Islington	426	(26)	67	88	555
Cornwall and Isles of Scilly	426	35	(15)	(18)	428
County Durham	426	(4)	49	(19)	452
Coventry	426	(3)	28	(17)	434
Croydon	426	(21)	(10)	35	430
Doncaster	426	(9)	39	(18)	438
Dorset	426	62	(37)	(14)	437
Dudley	426	(6)	(6)	(18)	396
Ealing, Hammersmith and Hounslow	426	(27)	25	55	479
East and North Hertfordshire	426	(11)	(43)	17	389
East Kent	426	41	(12)	15	470
East Lancashire	426	(9)	48	(18)	447
East London and the City	426	(35)	76	71	538
East Norfolk	426	26	(30)	(18)	404
East Riding	426	0	3	(16)	413
East Surrey	426	15	(59)	19	401
East Sussex, Brighton and Hove	426	67	(16)	14	491
Enfield and Haringey	426	(19)	20	50	477
Gateshead and South Tyneside	426	0	58	(18)	466
Gloucestershire	426	14	(34)	(16)	390
Herefordshire	426	18	(36)	(17)	391
Hillingdon	426	(13)	(23)	36	426
Isle of Wight	426	71	(15)	8	490
Kensington, Chelsea and Westminster	426	(18)	30	104	542
Kingston and Richmond	426	0	(34)	40	432
Lambeth, Southwark and Lewisham	426	(26)	65	67	532
Leeds	426	(6)	22	(16)	426
Leicestershire	426	(11)	(15)	(16)	384
Lincolnshire	426	19	(15)	(19)	411
Liverpool	426	(10)	81	(19)	478
Manchester	426	(17)	103	(18)	494
Merton, Sutton and Wandsworth	426	(11)	6	37	458
Morecambe Bay	426	26	(3)	(18)	431
Newcastle and North Tyneside	426	1	54	(19)	462
North and East Devon	426	45	(33)	(16)	422
North and Mid Hampshire	426	(21)	(49)	10	366
North Cheshire	426	(21)	24	(16)	413
North Cumbria	426	5	(3)	(15)	413

Annex 4: Calculation of 1996–97 Weighted Capitation Targets: Further Analysis—*continued*

	A	B	C	D	E
	Unweighted Target per head of crude population	*Age Weighting increases/ (decreases) target by*	*Needs Weighting increases/ (decreases) target by*	*MFF weighting increases/ (decreases) target by*	*Age, Need and MFF Weighted Target per head of crude population*
	£	£	£	£	£
North Derbyshire	426	9	(2)	(18)	415
North Essex	426	6	(35)	11	408
North Nottinghamshire	426	(8)	11	(19)	410
North Staffordshire	426	(4)	30	(19)	433
North West Anglia	426	5	(13)	(15)	403
North West Lancashire	426	32	29	(18)	469
North Yorkshire	426	17	(29)	(15)	399
Northamptonshire	426	(15)	(22)	(12)	377
Northumberland	426	3	7	(16)	420
Nottingham	426	(5)	13	(18)	416
Oxfordshire	426	(18)	(44)	10	374
Portsmouth and South East Hampshire	426	6	(17)	10	425
Redbridge and Waltham Forest	426	(8)	11	41	470
Rotherham	426	(12)	37	(20)	431
Salford and Trafford	426	2	41	(21)	448
Sandwell	426	2	41	(20)	449
Sefton	426	22	19	(19)	448
Sheffield	426	8	38	(19)	453
Shropshire	426	(1)	(16)	(18)	391
Solihull	426	(7)	(29)	(13)	377
Somerset	426	30	(38)	(16)	402
South and West Devon	426	34	(11)	(17)	432
South Cheshire	426	(4)	(17)	(15)	390
South Derbyshire	426	(6)	0	(19)	401
South Essex	426	(1)	(18)	(16)	423
South Humber	426	3	5	(19)	415
South Lancashire	426	(7)	(4)	(5)	400
South Staffordshire	426	(22)	(19)	(15)	370
Southampton and South West Hampshire	426	11	(26)	9	420
St. Helen's and Knowsley	426	(20)	53	(18)	441
Stockport	426	(2)	(7)	(14)	403
Suffolk	426	16	(38)	(15)	389
Sunderland	426	(18)	65	(20)	453
Tees	426	(20)	50	(18)	438
Wakefield	426	(14)	33	(19)	426
Walsall	426	(12)	27	(18)	423
Warwickshire	426	(4)	(20)	(14)	388
West Hertfordshire	426	(8)	(40)	20	398
West Kent	426	(10)	(29)	15	402
West Pennine	426	(13)	42	(18)	437
West Surrey	426	1	(57)	16	386
West Sussex	426	51	(43)	14	448
Wigan and Bolton	426	(15)	47	(18)	440
Wiltshire	426	(4)	(36)	(13)	373
Wirral	426	11	29	(19)	447
Wolverhampton	426	(2)	39	(19)	444
Worcestershire	426	(3)	(33)	(14)	376

ANNEX 5

1996–97 Weighted Capitation Distance from Targets: based on HA boundaries as at 1 April 1996

Health Authorities	*Distance from Weighted Capitation Target*	
	£000s	*%*
Avon	3,405	0.88
Barking and Havering	−157	−0.09
Barnet	6,413	4.67
Barnsley	−2,763	−2.69
Bedfordshire	−12,277	−5.71
Berkshire	−10,607	−3.67
Bexley and Greenwich	4,407	2.19
Birmingham	18,192	4.07
Bradford	1,307	0.63
Brent and Harrow	9,535	4.60
Bromley	−5,924	−4.61
Buckinghamshire	−9,653	−3.87
Bury and Rochdale	−2,118	−1.26
Calderdale and Kirklees	2,770	1.12
Cambridge and Huntingdon	−4,107	−2.55
Camden and Islington	26,979	13.08
Cornwall and Isles of Scilly	−909	−0.43
County Durham	−4,508	−1.64
Coventry	8	0.01
Croydon	−2,974	−2.12
Doncaster	−2,848	−2.20
Dorset	3,356	1.12
Dudley	−1,777	−1.43
Ealing, Hammersmith and Hounslow	10,941	3.50
East and North Hertfordshire	613	0.32
East Kent	−14,382	−5.19
East Lancashire	1,608	0.70
East London and the City	9,610	2.93
East Norfolk	−2,619	−1.04
East Riding	366	0.15
East Surrey	2,497	1.52
East Sussex, Brighton and Hove	−18,665	−5.21
Enfield and Haringey	2,506	1.11
Gateshead and South Tyneside	3,084	1.84
Gloucestershire	9,949	4.61
Herefordshire	1,406	2.17
Hillingdon	3,119	3.02
Isle of Wight	1,347	2.20
Kensington, Chelsea and Westminster	−653	−0.35
Kingston and Richmond	6,896	5.15
Lambeth, Southwark and Lewisham	−1,386	−0.35
Leeds	1,447	0.47
Leicestershire	−9,606	−2.70
Lincolnshire	3,497	1.38
Liverpool	3,594	1.59
Manchester	16,689	7.87
Merton, Sutton and Wandsworth	8,894	3.12
Morecambe Bay	5,832	4.36
Newcastle and North Tyneside	8,258	3.75
North and East Devon	4,413	2.21
North and Mid Hampshire	−527	−0.26
North Cheshire	10,197	7.98
North Cumbria	1,245	0.95
North Derbyshire	−1,350	−0.86
North Essex	−21,792	−6.11
North Nottinghamshire	−810	−0.50
North Staffordshire	−3,514	−1.71
North West Anglia	−2,403	−1.45
North West Lancashire	−5,862	−2.67
North Yorkshire	−2,427	−0.83

Annex 5: 1996–97 Weighted Capitation Distance from Targets: based on HA boundaries as at 1 April 1996—*continued*

Health Authorities	*Distance from Weighted Capitation Target*	
	£000s	*%*
Northamptonshire	1,363	0.59
Northumberland	−969	−0.74
Nottingham	−7,029	−2.61
Oxfordshire	−11,811	−5.24
Portsmouth and South East Hampshire	−4,624	−2.04
Redbridge and Waltham Forest	−2,779	−1.29
Rotherham	−1,542	−1.40
Salford and Trafford	4,878	2.45
Sandwell	1,735	1.32
Sefton	626	0.48
Sheffield	8,285	3.47
Shropshire	−2,737	−1.65
Solihull	1,402	1.85
Somerset	−1,264	−0.65
South and West Devon	3,187	1.25
South Cheshire	655	0.25
South Derbyshire	3,700	1.66
South Essex	−23,355	−7.88
South Humber	3,080	2.35
South Lancashire	2,383	1.91
South Staffordshire	3,754	1.73
Southampton and South West Hampshire	−10,996	−4.91
St. Helen's and Knowsley	−1,057	−0.72
Stockport	−2,945	−2.51
Suffolk	660	0.26
Sunderland	−687	−0.51
Tees	716	0.29
Wakefield	4,306	3.17
Walsall	−2,337	−2.09
Warwickshire	8,205	4.25
West Hertfordshire	2,955	1.43
West Kent	−15,284	−3.95
West Pennine	−3,305	−1.59
West Surrey	7,810	3.18
West Sussex	−15,102	−4.64
Wigan and Bolton	−9,321	−3.63
Wiltshire	9,989	4.47
Wirral	−609	−0.41
Wolverhampton	−940	−0.87
Worcestershire	1,239	0.61
ENGLAND		

Source: PE 1M, Table 1, (DoH).

MINUTES OF PROCEEDINGS RELATING TO THE REPORT

Thursday 24 June 1996

Members present:

Mrs Marion Roe, in the Chair

Mr Hugh Bayley
Mr David Congdon
Alice Mahon
Lady Olga Maitland
Mr John Marshall
Sir Roger Sims
Rev Martin Smyth
Mr John Whittingdale
Audrey Wise

The Committee deliberated.

Draft Report, proposed by the Chairman (Allocation of Resources to Health Authorities), brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 115 read and agreed to.

Ordered, That the following papers be annexed to the Report: Tables 1 to 5.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the provisions of Standing Order No.116 (Select committees (reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House. — (*The Chairman.*)

Several Memoranda were ordered to be reported to the House.

[Adjourned to a day and time to be fixed by the Chairman.

LIST OF ABBREVIATIONS USED IN THE REPORT

DoH	Department of Health
DHA	District Health Authority
HCHS	Hospitals and Community Health Services
HFMA	Healthcare Financial Management Association
MFF	Market Forces Factor
NAHAT	National Association of Health Authorities and Trusts
NES	New Earnings Survey
ONS	Office for National Statistics
PAMs	Professions Allied to Medicine
P&T	Professional & Technical
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority
SMR	Standardised Mortality Ratio

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UNPUBLISHED MEMORANDA

Additional memoranda have been received from the following and have been reported to the House, but to save printing costs they have not been printed. Copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 0171-219 3074). Hours of inspection are from 9.30am to 5.30pm on Mondays to Fridays.

Warwickshire: North Fundholding Group [PE 6]

The Association of Metropolitan Authorities and the Association of County Councils [PE 7]

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The Association of Directors of Social Services [PE 14]

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North West Surveys and Research [PE 22]

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